

Patient Registration

Please print clearly

Name: _____ Date of Birth: _____
(Last name) (Middle Initial) (First name)

Home Address: _____
(Street) (City) (State) (Zip)

Cell Phone: _____ Email: _____

Gender: _____ Marital Status: _____ Race: _____

Are you Hispanic or Latino?: _____

Emergency Contact

Name: _____ Relationship: _____
(Last name) (First name)

Home Address: _____
(Street) (City) (State) (Zip)

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Insurance Information

Subscribers Information

Name: _____ Date of Birth: _____
(Last name) (Middle Initial) (First name)

Insurance Name: _____

Subscriber ID #: _____ Group Number: _____ Relationship: _____

Visit gvsu.edu/campushealth for services, locations and hours.

Metro Health GVSU Campus Health Center

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Allendale, MI 49401

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