Patient Registration Form Patient Number _____

Name: _____ _____ _____
FIRST MI LAST

Date of Birth: _____ / _____ / _____ **Sex at Birth:** ( ) Male ( ) Female
PLEASE CHECK ONE

Social Security Number: _____ - _____ - _____

Street Address: _____ **PO Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Telephone: (_____) _____ **Work Phone:** (_____) _____

Cell Phone: (_____) _____ **Email Address:** _____

Marital Status: _____ **Student Status:** ( ) Full Time ( ) Part Time
PLEASE CHECK ONE IF APPLICABLE

Ethnicity (CHECK ONE)**:** ( ) Hispanic/Latino ( ) Non-Hispanic/Latino **Primary Language:** _____

Race (CHECK ONE)**:** ( ) American Indian/Alaska Native ( ) Asian ( ) Black/African American
( ) Native Hawaiian ( ) Pacific Islander ( ) White ( ) More than 1 race

Spouse's Name: _____ **Date of Birth:** _____ / _____ / _____

Patient's Employer: _____ **Spouse's Employer:** _____

Emergency Contact: _____ **Telephone:** (_____) _____

Responsible Party Information: (Who Pays the Bills?) **Guarantor Name:** _____

Telephone: (_____) _____ **Work Phone:** (_____) _____

Relationship to Patient: _____ **Date of Birth:** _____ / _____ / _____

Street Address: _____ **PO Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security Number: _____ - _____ - _____ **Employer:** _____

If Patient is a Minor:

Parent/Legal Guardian of Minor (1)

Name: _____ _____ _____
FIRST MI LAST

Relationship to Patient: _____ **Date of Birth:** _____ / _____ / _____

Telephone: (_____) _____ **Work Phone:** (_____) _____

Please Continue on Next Page

Patient Registration Form (Page 2) Patient Number _____

Parent/Legal Guardian of Minor (2) *[If Applicable]*

Name: _____ _____ _____
FIRST MI LAST

Relationship to Patient: _____ **Date of Birth:** _____ / _____ / _____

Telephone: (_____ **)** _____ **Work Phone: (** _____ **)** _____

(*IMPORTANT NOTICE: The Parent/Legal Guardian Information Listed is Not Authorization and/or Designation of a Personal Representative***)**

Demographic Characteristics

Characteristics – Special Populations (Data used by Goshen Medical Center due to being a Federally Qualified Health Center which offers the Sliding Fee Discount based on family size and income.)

How long have you lived in the United States? _____ years, _____ months

Are you a US Veteran? **(** **)** Yes **(** **)** No

Persons In Household (PLEASE CIRCLE) 1 2 3 4 5 6 7 8 9 10 Other _____

Household Income Range (PLEASE CIRCLE):

<$11,500 *$11,501-15,000* *$15,001-20,000* *$20,001-30,000* *$30,001-40,000*
$40,001-50,000 *$50,001-60,000* *$60,001-70,000* *$70,001-80,000* *$80,001-90,000* *>$90,000*

Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry? **(** **)** Yes **(** **)** No **If yes, which applies?** (PLEASE SEE BELOW)

(**)** Year Round Employment (permanent residence in area)
(**)** Migrant (establishes temporary residence in area)
(**)** Seasonal (permanent residence in area)

Type of Housing for patient or patient's parent/guardian if a minor (CHECK ONE)**:**

(**)** Public Housing **(** **)** Homeless Shelter **(** **)** Doubled Up (live with another person or family unit)

(**)** Rent or own Home **(** **)** Street **(** **)** Transitional (live place to place) **(** **)** Other _____

Sexual Orientation (CHECK ONE)**:**

(**)** Lesbian or Gay
(**)** Straight (not Lesbian or Gay)
(**)** Bisexual
(**)** Something Else
(**)** Don't Know
(**)** Choose Not to Disclose

Gender Identity (CHECK ONE)**:**

(**)** Male
(**)** Female
(**)** Transgender Male/Female-to-Male
(**)** Transgender Female/Male-to-Female
(**)** Other
(**)** Choose Not to Disclose

Is this visit due to an Accident/Injury: Yes_____ No_____ If yes, Date of Injury: _____ / _____ / _____

I certify that the information given above is true and correct _____
(Patient Signature)

_____
(Parent/Guardian signature if patient a minor)

_____
(Print Name)

_____ / _____ / _____
(Date)

NOTE: Receptionist may request payer source/insurance card or picture identification prior to being seen by provider.

APR2016REV