GraceCottage FAMILY HEALTH & HOSPITAL

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: ________________________________ First Name: ________________________M.I._____

Former Name: ________________ Date of Birth:_______________ Email Address:_________________________________

Mailing Address:____

Street Address (if different than mailing):____

City:____State:_______________________Zip code:________________

Home Phone #: ______________________Mobile/Cell Phone #: ______________________Work Phone: ________________

Preferred Method of Contact: Please circle **TEXT** **EMAIL** **TELEPHONE**
We use an automated system for reminder calls and outreaches, you can opt out of this if you wish

Birth Sex: Please check box below

☐ Female	☐ Male	☐ Other/Unknown

How do you identify?: Please check box below

☐ Female	☐ Male	☐ Other/Unknown

Pronoun: Please check box below

☐ He/Him/His	☐ No Pronouns	☐ Other: _________________
☐ Please Ask	☐ She/Her/Hers	☐ They/Them/Theirs

Race(s): Please check box(es) below

☐ Black or African American
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Asian Indian
☐ Other Asian
☐ American Indian or Alaska Native
☐ White
☐ Other Race
☐ Prefer not to answer

Ethnicity: Please check box below

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Cuban
☐ Mexican/Mexican American/ Chicano/a
☐ Puerto Rican
☐ Prefer not to answer

Marital Status: _____________________ Preferred Language:___________________ Religion:________________________

Preferred Pharmacy: ___________________________________ Location: ____

PATIENT REGISTRATION FORM

EMPLOYER INFORMATION

Employment Status: Full time Part time Not employed Disabled Retired Student Self Employed ***(circle)***

Retirement/Disability Date (if applicable): ______________________

Employer:____Occupation:______________________________________

Address:____

State:______________________________Zip: ____________________________Phone:______________________________________

GUARANTOR (Responsible party for billing)/EMERGENCY CONTACT INFORMATION

Guarantor Name:____DOB:__________________Phone #:_________________________

Relationship to Patient: ____________________________________

Emergency Contact: ____________________________________ DOB: _________________ Phone:___________________________

Relationship to Patient: _________________________________

INSURANCE INFORMATION

Primary Insurance:____

Primary Insured Name:____*DOB:________________________________

Relationship to Patient:_____________________________________Policy #:____

Group #:____Effective Date:___________________Expiration Date:___________

Secondary Insurance:____

Secondary Insured Name:____DOB:_________________________________

Relationship to Patient:______________________________________Policy #:____

Group #:____Effective Date:_________________ ExpirationDate:____________

Is this Worker's Comp./Motor Vehicle Accident or Other Liability Claim? __________If Yes, date of injury_________________

Claim #_______________________________________Contact Name/Case Worker:______________________________________

Liability Insurance Name:____________________________________Phone #____

Address:____

I certify that the above information is correct to the best of my knowledge:

SIGNATURE: ____DATE:___________________________________

Name (Print): ____Relationship to patient:___________________