GraceCottage FAMILY HEALTH & HOSPITAL

NEW 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#: _____

How did you hear about us? _____

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	☐ Vietnamese
☐ Native Hawaiian	☐ Asian Indian
☐ Samoan	☐ Other Asian
☐ Other Pacific Islander	☐ American Indian or Alaska Native
☐ Chinese	☐ White
☐ Filipino	☐ Other Race
☐ Japanese	☐ Prefer Not to Answer
☐ Korean	

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: _____

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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:_____ Expiration Date:_____

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:_____