Grace Health

Adult Demographics

Date _____

Last Name First Middle Initial			Date of Birth	Birth Sex ❑ Male ❑ Female	Social Security Number
Previous Last Names		Preferred Name		E-mail address	
Gender Identity	❑ Male ❑ Female ❑ Transgender Male (F to M) ❑ Transgender Female (M to F) ❑ Other_____ ❑ Choose not to disclose			Current Gender ❑ Male ❑ Female ❑ Unknown ❑ Undifferentiated	
Sexual Orientation	❑ Straight (not Lesbian/Gay) ❑ Lesbian/Gay ❑ Bisexual ❑ Don't know ❑ Other_____ ❑ Choose not to disclose				
Preferred Pronouns	❑ He, Him, His ❑ She, Her, Hers ❑ They, Them, theirs ❑ Ze, Hir ❑ Other_____ ❑ Choose not to disclose ❑ Unknown				
Street Address Apartment # City State / Zip Code					
Home Telephone Number ( )	Cell Phone Number ( )	Message Telephone Number ( )	Marital Status ❑ S ❑ M ❑ W ❑ D ❑ Sep		
Employer				Work Telephone Number ( )	
Employer's Address					
Spouse's Name				Spouse's Date of Birth	
Local Contact for Emergencies		Relationship to Patient		Emergency Contact Phone ( )	
❑ Patient has legal guardian		Guardian's Name		Guardian's Phone Number ( )	
Guardian's Address					
Race	May Choose More than One. Circle Top Choice. ❑ White ❑ Black / African American ❑ Native Hawaiian ❑ Samoan ❑ Asian ❑ American Indian / Alaska Native ❑ Other Pacific Islander ❑ Other Asian ❑ Chinese ❑ Guamanian or Chamorro ❑ Japanese ❑ Asian Indian ❑ Filipino ❑ Vietnamese ❑ Korean ❑ Choose not to disclose ❑ Other_____				
Ethnicity	May Choose More than One. Circle Top Choice. ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Mexican ❑ Mexican American ❑ Chicano/o ❑ Puerto Rican ❑ Cuban ❑ Spanish ❑ Unreported/Choose not to disclose				
Language	❑ English ❑ Spanish ❑ Burmese ❑ Other_____				
Do you need help finding a place to live? ❑ Yes ❑ No		Are you a military veteran? ❑ Yes ❑ No			

Insurance Information ❑ **No Insurance Coverage**

❑ Medicaid	Medicaid Number			
❑ Medicare	Medicare Number			
❑ Other	Insurance Name	Group Number	Policy Number	
	Subscriber/Employee	Patient is: ❑ Subscriber ❑ Spouse ❑ Dependent	Subscriber's Date of Birth	Subscriber's Social Security Number
❑ Other	Insurance Name	Group Number	Policy Number	
	Subscriber/Employee	Patient is: ❑ Subscriber ❑ Spouse ❑ Dependent	Subscriber's Date of Birth	Subscriber's Social Security Number

(over)

❑ Yes ❑ No	Grace Health offers discounted fees to those who qualify. If you would like information about our Schedule of Discounts Program, please mark “Yes”.

Reporting yearly household size and income is a government requirement that will allow Grace Health to continue to receive funding to provide special services for our patients. Please support these programs by providing the following information:

Number of people living in home: _____ *Total household income:* _____ *Choose not to disclose:* _____

Completed forms may be emailed to: *receptionnoreply@gracehealthmi.org* Please call 269-965-8866 if you have questions or need assistance.