Grace Health

Pediatric Demographics

Date ________________

Patient's Last Name	First	Middle Initial	Date of Birth	Sex	Social Security Number
Preferred Name					
Street Address	Apartment #	City		State / Zip Code	
Home Telephone Number ( )	Cell Phone No. for ______________ ( )	Message Telephone Number ( )			

Parent/Guardian		Parent/Guardian	
Relationship ❑ Legal/Biological Parent ❑ Foster Parent ❑ Legal Guardian		Relationship ❑ Legal/Biological Parent ❑ Foster Parent ❑ Legal Guardian	
Parent's Date of Birth	Parent's Social Security Number	Parent's Date of Birth	Parent's Social Security Number
Parent's Address (if different from patients)		Parent's Address (if different from patients)	
Parent's Employer		Parent's Employer	
Parent's Work Phone Number		Parent's Work Phone Number	
Parent's Email Address		Parent's Email Address	

Local Contact for Emergencies	Relationship to Patient	Emergency Contact Telephone Number ( )

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

Insurance Information ❑ No Insurance Coverage

❑ Medicaid	Medicaid 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.