Grace Health

- Adult Demographics -

Date _____

Last Name	First	Middle Initial	Date of Birth	Birth Sex ❑ Male ❑Female	Social Security Number
Previous Last Names				E-mail address	
Gender Identity	❑ Male ❑ Female ❑ Transgender Male (F to M) ❑ Transgender Female (M to F) ❑ Other_____ ❑ Choose not to disclose				
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		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 ( )	
Race	May Choose More than One. Circle Top Choice. ❑ White ❑ Black / African American ❑ Native Hawaiian ❑ Choose not to disclose ❑ Asian ❑ American Indian / Alaska Native ❑ Other Pacific Islander ❑ Other_____				
Ethnicity	May Choose More than One. Circle Top Choice. ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ 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

❑ 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 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 selecting your income range.

Please choose one income level that best describes your total household income: Number of people living in home _____

❑ **0 - $25,999** ❑ **$26,000 - $50,999** ❑ **$51,000 - $75,999** ❑ **$76,000+** ❑ **Do not want to answer**