

Adult Demographics

Date _____

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

Insurance Information **No Insurance Coverage**

<input type="checkbox"/> Medicaid	Medicaid Number			
<input type="checkbox"/> Medicare	Medicare Number			
<input type="checkbox"/> Other	Insurance Name	Group Number	Policy Number	
	Subscriber/Employee	Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Subscriber's Date of Birth	Subscriber's Social Security Number
<input type="checkbox"/> Other	Insurance Name	Group Number	Policy Number	
	Subscriber/Employee	Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> 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 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:* _____