

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	
Street Address			Apartment #	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

(over)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Grace Health offers discounted fees to those who qualify. If you would like information about our Schedule of Discounts Program, please mark "Yes".
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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.