

Name: \_\_\_\_\_  
FIRST MI LASTDate of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex at Birth: ( ) Male ( ) Female  
PLEASE CHECK ONE

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Student Status: ( ) Full Time ( ) Part Time  
PLEASE CHECK ONE IF APPLICABLE

Ethnicity (CHECK ONE): ( ) Hispanic/Latino ( ) Non-Hispanic/Latino Primary Language: \_\_\_\_\_

Race (CHECK ONE): ( ) American Indian/Alaska Native ( ) Asian ( ) Black/African American  
( ) Native Hawaiian ( ) Pacific Islander ( ) White ( ) More than 1 race

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Employer: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Responsible Party Information: (Who Pays the Bills?) Guarantor Name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_

**If Patient is a Minor:****Parent/Legal Guardian of Minor (1)**Name: \_\_\_\_\_  
FIRST MI LAST

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

*Please Continue on Next Page*



Patient Registration Form (Page 2) Patient Number \_\_\_\_\_

Parent/Legal Guardian of Minor (2) [If Applicable]

Name: \_\_\_\_\_ FIRST MI LAST

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

(\*\*\*)IMPORTANT NOTICE: The Parent/Legal Guardian Information Listed is Not Authorization and/or Designation of a Personal Representative(\*\*\*)

Demographic Characteristics

Characteristics - Special Populations (Data used by Goshen Medical Center due to being a Federally Qualified Health Center which offers the Sliding Fee Discount based on family size and income.)

How long have you lived in the United States? \_\_\_\_\_ years, \_\_\_\_\_ months

Are you a US Veteran? ( ) Yes ( ) No

Persons In Household (PLEASE CIRCLE) 1 2 3 4 5 6 7 8 9 10 Other \_\_\_\_\_

Household Income Range (PLEASE CIRCLE):

- <\$11,500 \$11,501-15,000 \$15,001-20,000 \$20,001-30,000 \$30,001-40,000
\$40,001-50,000 \$50,001-60,000 \$60,001-70,000 \$70,001-80,000 \$80,001-90,000 >\$90,000

Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry? ( ) Yes ( ) No If yes, which applies? (PLEASE SEE BELOW)

- ( ) Year Round Employment (permanent residence in area)
( ) Migrant (establishes temporary residence in area)
( ) Seasonal (permanent residence in area)

Type of Housing for patient or patient's parent/guardian if a minor (CHECK ONE):

- ( ) Public Housing ( ) Homeless Shelter ( ) Doubled Up (live with another person or family unit)
( ) Rent or own Home ( ) Street ( ) Transitional (live place to place) ( ) Other \_\_\_\_\_

Sexual Orientation (CHECK ONE):

- ( ) Lesbian or Gay
( ) Straight (not Lesbian or Gay)
( ) Bisexual
( ) Something Else
( ) Don't Know
( ) Choose Not to Disclose

Gender Identity (CHECK ONE):

- ( ) Male
( ) Female
( ) Transgender Male/Female-to-Male
( ) Transgender Female/Male-to-Female
( ) Other
( ) Choose Not to Disclose

Is this visit due to an Accident/Injury: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the information given above is true and correct \_\_\_\_\_

(Patient Signature)

(Parent/Guardian signature if patient a minor)

(Print Name)

\_\_\_\_/\_\_\_\_/\_\_\_\_ (Date)

NOTE: Receptionist may request payer source/insurance card or picture identification prior to being seen by provider.

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