Ingham Community Health Centers: **Ingham County Health Department**

REGISTRATION FORM - PATIENT INFORMATION

Patient's Legal Name: _____
First Name Middle Initial Last Name

Preferred Name: _____
First Name Last Name

Date of Birth: ____/____/____ Soc Sec # _____
Month Day Year

Address: _____ Lot or Apt # _____ City: _____

State: _____ Zip Code: _____ County: _____ Daytime Phone #: _____

1. Sex at birth (Assigned on original birth certificate) : ❒ Male ❒ Female	2. **Gender Identity**: ❒ Male ❒ **Fe**male ❒ Female to Male (FTM) Transgender Male ❒ Male to Female (MTF)Transgender Female ❒ Genderqueer, neither exclusively male nor female ❒ Additional gender category or other, please specify: _____ ❒ Choose not to disclose	3. **Sexual Orientation:** ❒ Straight/Heterosexual ❒ Lesbian/Gay/Homosexual ❒ Bisexual ❒ Don't Know ❒ Choose not to disclose ❒ Something else, please describe:	**4. Preferred Pronouns (pronoun that you choose to use for yourself, if applicable):** ❒ He, Him, His ❒ She, Her, Hers ❒ They, Them, Theirs ❒ Ze, Hir ❒ Asked but unknown ❒ Decline to answer ❒ Other
While ICHC recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.			
5. **May we contact you by**: **Phone** ❒ Yes ❒ No **Text** ❒ Yes ❒ No **Mail** ❒ Yes ❒ No **Email** ❒ Yes ❒ No If Email was marked Yes, please provide address below: _____	**6. Patient's Marital Status:** ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Never Married ❒ Partner	7. **Does Patient speak English** ❒ Yes ❒ No **Language spoken at Home:** ❒ English ❒ Spanish ❒ Arabic ❒ Nepali ❒ Somali ❒ Other (specify): _____	**8. Patient Portal:** **Would you like Patient Portal Access to your Health Records?** ❒ **Yes** ❒ **No** ❒ **Already Have** **If so, please provide your email address in box #5.**

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9. Patient's Housing Status:	10. Patient's Race (select all that apply):	11. Patients Ethnicity	12. Is Patient a United States Military Veteran:
❒ Doubling up ❒ Not homeless ❒ Other ❒ Shelter ❒ Street ❒ Transitional ❒ Unknown/Unreported ❒ Permanent Supportive Housing (*i.e. AFC, assisted living, senior housing*)	**❒ American Indian** **❒ Asian** **❒ Black/African American** **❒ Native Hawaiian** **❒ Pacific Islander** **❒ White** **❒ Unknown/Not Reported**	**❒ Arab/Chaldean** **❒ Hispanic** **❒ Non-Hispanic** **❒ Unknown/Refused** **❒ Other (Specify)** _____	**❒ Yes** **❒ No** **13. Is Patient a Migrant Worker:** **❒ Yes** **❒ No**

Emergency Contact: Name: _____

Phone #_____ Relationship to Patient:_____

For minor children, please provide the names, telephone numbers, and addresses of <u>both</u> parents:

Mother's Name:_____ Birth Date: _____ Phone #_____

Address: _____

Father's Name:_____ Birth Date: _____ Phone #_____

Address:_____

Does the patient have a Legal Guardian or Foster Parent? ❒ No ❒ Yes - please complete the following:

❒ Foster Parent – Name:_____ Birth Date:_____

If yes, Case Worker/Agency:_____

❒ Legal Guardian – Name:_____ Birth Date:_____

Patient/Parent/Legal Guardian Signature: _____

Date: _____