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

REGISTRATION FORM - PATIENT INFORMATION____

Patient's Name:____
First Name Middle Initial Last Name

Date of Birth:__________/__________/__________Soc Sec #______________________________
Month Day Year

Address:________________________________ Lot or Apt #__________City:____________________

State: ______________ Zip Code: ____________ County: __________Daytime Phone #:____________________

May We Contact You By: **Phone** ❐ Yes ❐ No **Text** ❐ Yes ❐ No **Mail** ❐ Yes ❐ No **Email** ❐ Yes ❐ No If Yes, Please provide Email Address: ____

Would you like Patient Portal Access to your health records? ❐ Yes ❐ No

If Yes, ask front desk staff for your secure portal access number to enroll. Would you like assistance enrolling? ❐ Yes ❐ No

Emergency Contact: Name: ____________________Phone #____________________ Relationship to Patient:__________

Sex at birth: ❐ Male ❐ Female ❐ Intersex

Current Gender: ❐ Male ❐ Female ❐Genderqueer/Non-binary ❐ Transgender Man (FTM) ❐ Transgender Woman (MTF)

❐ Other ________________________ ❐ Prefer not to share (*This is your internal sense of yourself as male, female, or another gender).*

Sexual Orientation: ❐Bisexual ❐ Straight/Heterosexual ❐ Homosexual/Gay/Lesbian ❐ Other ❐ Prefer not to share
This is how you identify your personal physical and emotional attraction to others.

Pronouns: ❐He/him/his ❐ She/her/hers ❐They/them/theirs ❐ Zie/zir/zirs ❐ Other ❐ Prefer not to share
These are the words you would like us to use to address you.

Patient's Marital Status: ❐ Married ❐ Separated ❐ Divorced ❐ Widowed ❐ Never Married ❐ Partner

Patient's Race: ❐ American Indian ❐ Asian ❐ Black/African American ❐ Native Hawaiian ❐ Pacific Islander ❐ White ❐ Unknown/Not Reported **(select all that apply)**

Patient's Ethnicity: ❐ Arab/Chaldean ❐ Hispanic ❐ Non-Hispanic ❐ Unknown/Refused ❐Other (specify)______________

Language spoken at home:❐ English ❐ Spanish ❐ Arabic ❐ Nepali ❐ Somali ❐ Other (specify) ________________

Does Patient speak English ❐ Yes ❐ No

Is Patient a United States Military Veteran: ❐ Yes ❐ No

Is Patient a Migrant Worker: ❐ Yes ❐ No

Patient's Housing Status: ❐ Not homeless ❐ Homeless shelter ❐ Transitional ❐ Doubled up ❐ Street ❐ Other

For minor children, please provide the names, telephone numbers, and addresses of both 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:________________

Revised 09/06/18