GOSHEN MEDICAL CENTER, INC.

Patient Registration Chart Number _____

Name: _____ _____ _____
Last First Middle

Date of Birth: _____/_____/_____ **Social Security Number**: _____ **Sex**: _____

Street Address: _____

PO Box_____ **City**_____ **State**_____ **Zipcode**_____

Marital Status: _____ **Student**: ( )Full Time ( )Part Time **Primary Language**: _____

Ethnicity (check one) ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ More than 1 race

Characteristics– Special Populations (Data used by Goshen Medical Center due to being a Federal Qualified Health Care Center which offers the Sliding Fee based on income along with number of family members.)

How long have you lived in the United States? _____years, _____months Are you a US Veteran? ☐Yes ☐No

Household Income Range (circle one) <$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

Persons In Household (circle one) 1 2 3 4 5 6 7 8 9 10 other _____

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? ☐ 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 _____

Home Telephone: (____)_____ **Work Phone**: (____)_____ **Cell Phone**: (____)_____

Patient's Employer: _____ **Address**: _____

Spouse's Name: _____ **Date of Birth**: _____/_____/_____

Spouse's Employer: _____ **Address**: _____

In case of Emergency, Center may Contact: Name: _____ Telephone: (____)_____

Responsible Party Information: (Who Pays the Bills?) Name: _____

Telephone: (____)_____Work Phone: (____)_____ Relationship_____

Address:_____City_____State_____ Zipcode_____

Employer: _____Social Security Number: _____ Date of Birth: _____/_____/_____

If Patient is a Minor:

Parent/Legal Guardian of Minor (1)

Full Name: _____ **Telephone**: (____)_____

Relationship to Patient: _____ **Work Phone**: (____)_____

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

Full Name: _____ **Telephone**: (____)_____

Relationship to Patient: _____ **Work Phone**: (____)_____

(IMPORTANT NOTICE: The Information Listed Above Is Not Authorization and/or Designation of a Personal Representative)

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) (Date)

_____ _____ ____/____/_____
(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. (Rev SEPT2014)