Gratiot County Free Clinic
PARTNERS IN PREVENTION PROVIDING ACCESS TO QUALITY HEALTHCARE

REGISTRATION FORM

DATE	BIRTH DATE AGE	☐ NEW ☐ RETURN

PATIENT INFORMATION

PATIENT NAME (LAST) (FIRST) (MIDDLE)				☐ MALE ☐ FEMALE
ADDRESS	CITY	STATE	ZIP CODE	
TELEPHONE ( )	EMAIL	SS#	MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ LEGALLY ☐ MARRIED ☐ WIDOWED SEPARATED	LANGUAGE

RACE

☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC / LATIN ☐ NATIVE AMERICAN / ALASKAN ☐ OTHER

EDUCATION

☐ HIGH SCHOOL ☐ GED ☐ SOME COLLEGE ☐ COLLEGE GRAD ☐ CURRENT STUDENT LAST GRADE COMPLETED _____

LIVING STATUS

☐ RENT/OWN ☐ HOME/APARTMENT ☐ FRIEND/RELATIVE ☐ SHELTER/STREET/CAR ☐ OTHER _____

INCOME

SOURCE OF INCOME (check all that apply)

☐ WAGE/SALARY ☐ UNEMPLOYMENT ☐ WORKMANS COMP/DISABILITY ☐ VA ☐ SOCIAL SECURITY/PENSION

☐ OTHER ☐ NONE (explain how expenses met)

EMPLOYER	OCCUPATION	EMPLOYER TELEPHONE ( )	HIRE DATE
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
HOURLY WAGE	AVE # HOURS/WEEK	ANNUAL INCOME	

SPOUSE/LEGAL GUARDIAN INFORMATION

NAME (LAST) (FIRST) (MIDDLE)			RELATIONSHIP
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE ( )	CELLPHONE ( )	SS#	BIRTH DATE
EMPLOYER	OCCUPATION	EMPLOYER TELEPHONE ( )	HIRE DATE
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
HOURLY WAGE	AVE # HOURS/WEEK	ANNUAL INCOME	

INSURANCE

SOURCE OF INSURANCE (check all that apply)

☐ MEDICARE ☐ MEDICAID (Monthly Spend Down) _____ ☐ VA ☐ NONE (Benefit Waiver) _____ ☐ OTHER _____

COVERED EXPENSES (check all that apply)

☐ OFFICE VISITS ☐ MEDICATION ☐ LAB, XRAY, ETC. ☐ INPATIENT HOSPITALIZATION ☐ N/A

NEAREST RELATIVE/FRIEND NOT RESIDING AT SAME ADDRESS

NAME (LAST) (FIRST) (MIDDLE)			RELATIONSHIP
ADDRESS	CITY	STATE	ZIP CODE
HOME TELEPHONE ( )		WORK TELEPHONE ( )	

PATIENT/LEGAL GUARDIAN SIGNATURE	DATE

OFFICE USE ONLY

SIGNATURE	DATE	SIGNATURE	DATE