Patient Registration Form

Muskegon Family Care

2201 S. Getty St. Muskegon Hts., MI 49444

MEDICAL SERVICES **231-739-9315-Office 231-733-3195-Fax**

Patient's Name:	Date of Birth: Social Security Number:
Street Address:	E-Mail:
City:	Zip Code:
Home Phone: ☐Preferred Work Phone: ☐Preferred Cell Phone: ☐Preferred	Emergency Contact : Phone: Relationship:
Gender: Male ☐ Female ☐	Married ☐ Divorced ☐ Single ☐ Child ☐
Race: African American/Black ☐ Caucasian/White ☐ Native Hawaiian ☐ Asian ☐ Hispanic/Latino ☐ American Indian or Alaska Native ☐ Refused to Report/Unreported ☐	Primary Language: English ☐ Spanish ☐ Japanese ☐ Vietnamese ☐ Sign Language ☐ Other ☐ (Please specify) _____
Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐	Homeless: Yes ☐ No ☐ If homeless, where do you stay?
Are you or any household member that contributes to the household income a migrant/seasonal worker? Yes ☐ No ☐	Military Veteran: Yes ☐ No ☐ If Yes, What Branch? _____ Active Military: Yes ☐ No ☐
If yes to above: Self ☐ Other Household Member ☐	Household Family Size (Including Patient) 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 and Up☐
Gross Monthly Household Income:	Occupation:
Medical Insurance:	Other Insurance:
Policy #	Policy #

FOR MINOR PATIENTS ONLY

Mother's Name:	DOB:	Social Security #
Street Address:		Phone:
City:		Zip Code:
Father's Name:	DOB:	Social Security #
Street Address:		Phone:
City:		Zip Code:

If Patient is a Minor: I (We), the undersigned, being the parent(s) or legal guardian(s), give medical care personnel at Muskegon Family Care permission to provide medical treatment as deemed necessary, regarding the above named minor. In my absence, this permission extends to visits when the following person(s) brings my child to the clinic.

Authorized person(s) other than parent/Guardian _____Phone #_____
Relationship to Patient_____

Authorized person(s) other than parent/Guardian _____Phone #_____
Relationship to Patient_____

Signature of Patient or Parent/Guardian _____ Date_____