Corewell Health™

PATIENT INFORMATION

Patient Name_____ **Birth Date** _____

Address_____ **Patient Phone** _____
Street City State Zip

Parent/Guardian Name_____ **Parent/Guardian Birth Date**_____

Parent/Guardian Phone # _____

Emergency Contact Name/Relation/Phone _____

Insurance Name: _____ **ID Number**: _____

Subscriber Name: _____ **Subscriber DOB**: _____

☐ I do not have medical insurance. ☐ Check here if you want us to contact you for Medicaid assistance

Race: ☐ White ☐ Black ☐ Multi-racial ☐ American Indian ☐ Asian/Pacific Islander ☐ Other
Ethnicity: ☐ Hispanic ☐ Arabic ☐ Other
Sex Assigned at birth: ☐ Female ☐ Male ☐ Intersex
Gender Identity: ☐ Male ☐ Female ☐ Third Gender/Non-binary ☐ Prefer to self-describe ☐ Prefer not to say
Preferred Language: ☐ English ☐ Spanish ☐ Arabic ☐ Other_____ **Deaf** ☐ Yes ☐ No **Blind** ☐ Yes ☐ No
Barriers to Learning: ☐ None ☐ Vision ☐ Hearing ☐ Reading ☐ Cognitive: _____ ☐ Other:_____

Medical Information

Current Allergies _____

Current Medications _____

Doctor Name _____ **Phone number** _____

Dentist Name _____ **Phone number** _____

Does the patient have any of the following? Please Circle YES or NO

Asthma	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No
Food Allergy	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No

List any other medical illness (past/present), surgeries or hospitalizations: _____

_____

Eyes ☐ Glasses ☐ Contact Lenses Date of last eye exam _____

*** TURN OVER*** MUST COMPLETE BOTH SIDES ***