

**EDWARD-ELMHURST HEALTH
EEH REGISTRATION FORM**
PLEASE **PRINT** ALL INFORMATION CLEARLY

PATIENT INFORMATION

Patient's **Legal Name:** _____ **DOB:** _____

Is address on ID current? Yes No If no, please enter current address below

<p>Current Address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p align="right">_____ Zip Code</p>	<p>Home Phone: (____) _____</p> <p>Work Phone: (____) _____</p> <p>Mobile Phone: (____) _____</p>
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Email Address: _____

<p>Sex</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p>Marital Status</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widow/Widower</p> <p><input type="checkbox"/> Separated</p>	<p>Ethnicity</p> <p><input type="checkbox"/> Hispanic or Latino</p> <p><input type="checkbox"/> Non-Hispanic or Latino</p> <p><input type="checkbox"/> Prefer not to answer</p> <p>(State and Local governments may use the data to help plan and administer bilingual programs for people of Hispanic origin.)</p>
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Preferred Language: _____ **Interpreter Needed:** Yes () No ()

Preferred Pharmacy: _____

Preferred Lab: _____

<p>Race</p> <p><input type="checkbox"/> White/Caucasian</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> American Indian/Alaska Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Other Race</p> <p><input type="checkbox"/> Native Hawaiian and Other Pacific Islander</p> <p><input type="checkbox"/> Multi-racial</p> <p><input type="checkbox"/> Prefer not to answer</p>	<p>PCP (Primary Care Physician) Dr. _____</p> <p>Employer Name: _____</p> <p>Employer Phone Number: _____</p> <p>Employer Address:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Occupation: _____</p> <p>Employment Status</p> <p><input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Military Duty</p>
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Emergency Contact(s)

Name	Relationship	Phone Number
_____	_____	(____) _____
_____	_____	(____) _____