



## Family Guest Registration Form

Patient Information			
Patient Name:			
Date of Birth:	SSN:	Phone:	
Patient Status:	<input type="checkbox"/> Pre-Transplant <input type="checkbox"/> Post-Transplant	Patient to Stay at Family House	<input type="checkbox"/> Y <input type="checkbox"/> N
Referring Transplant Center:			
<input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Pancreas	Special Needs:		
Responsible Party Primary Contact Information			
Name (if different from patient)			
Address:			
City:	State:	ZIP Code:	
Primary Phone:	Email:	Relationship to Patient:	
Emergency Contact			
Name of a person not residing with you:			
Address:			
City:	State:	ZIP Code:	Phone:
Relationship:			
Requested Check-In Date:		Anticipated Length of Stay:	
Other Guests in Apartment (2 per Bedroom plus 1 additional guest)			
Name:	Relationship to Patient:	Age:	
Name:	Relationship to Patient:	Age:	
Name:	Relationship to Patient:	Age:	
Name:	Relationship to Patient:	Age:	
Name:	Relationship to Patient:	Age:	
Name:	Relationship to Patient:	Age:	
Name:	Relationship to Patient:	Age:	
Your Vehicles			
Make and Color of Vehicle:			
Year:	License #:	State:	
Make and Color of Vehicle:			
Year:	License #:	State:	
Payment Information			
Who is responsible for rent payment?			
Method of Payment: <input type="checkbox"/> Check <input type="checkbox"/> Credit <input type="checkbox"/> Money Order <input type="checkbox"/> Other			
Signature of Applicant:			Date:
Signature of Mid-America Transplant Family House Staff:			Date:
Mid-America Transplant Family House Office Use Only			
1 Bedroom _____    2 Bedroom _____    3 Bedroom _____			Keys