PATIENT REGISTRATION FORM

neighborcare health

WELCOME! We are glad to be your health care partner. We collect the information below in order to provide you the best care possible. Thank you for completing the form fully.

Please complete sections 1–9.

1. PATIENT INFORMATION

NAME Last	First	Middle	Previous Last	Preferred Name

SOCIAL SECURITY NUMBER	DATE OF BIRTH / /	PATIENT'S SEX ⇨⇨ ❑ Male ❑ Female FOR INSURANCE AND REPORTING PURPOSES ONLY

BILLING ADDRESS LINE 1

BILLING ADDRESS LINE 2 | APT

CITY | STATE | ZIP

PREFERRED LANGUAGE (Check one)
❑ English ❑ Spanish ❑ Somali ❑ Vietnamese
❑ Other _____

MARITAL STATUS (Check one)
❑ Single ❑ Married ❑ Domestic Partner
❑ Legally Separated ❑ Divorced ❑ Widowed

MAIN PHONE ❑ Home ❑ Cell ❑ Work

STUDENT STATUS (Check one)
❑ Full Time ❑ Part Time ❑ Not a Student

ALTERNATE PHONE ❑ Home ❑ Cell ❑ Work

VETERAN STATUS
❑ Yes ❑ No

PERSONAL E-MAIL

SMOKER
❑ Yes ❑ No

2. DEMOGRAPHIC INFORMATION

INCOME	Gross annual household income	$
DISABLED/HANDICAPPED	Does patient have ongoing condition preventing daily activities?	❑ Yes ❑ No
TOTAL NUMBER IN HOUSEHOLD	Number of family members reported on federal income tax return?	
TOTAL NUMBER OF CHILDREN <18	Number of children in the household under age 18	

HOUSEHOLD STATUS (Check one)
Please describe the Head of Household
❑ Individual ❑ Single Female ❑ Single Male ❑ Two Parents ❑ Unknown

GENDER IDENTITY (Check one)
❑ Declined ❑ Female ❑ Female to Male
❑ Gender Queer ❑ Male ❑ Male to Female
❑ Other

SEXUAL ORIENTATION (Check one)
❑ Bisexual ❑ Declined ❑ Don't Know
❑ Lesbian, Gay or Homosexual ❑ Something Else
❑ Straight or Heterosexual

3. PLEASE PROVIDE THE NAMES OF YOUR CURRENT DOCTOR

MEDICAL	MENTAL HEALTH
DENTAL	PREGNANCY/MATERNITY CARE

4. PRIVACY NOTICE

I have received Neighborcare Health's Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information.	Initials

This form continues on reverse. Please complete all sections. ➲

PATIENT REGISTRATION FORM

neighborcare health

Continued from reverse.

5. EMERGENCY CONTACT

NAME Last	First	DATE OF BIRTH / /	SEX ❑ Male ❑ Female
ADDRESS	APT	RELATIONSHIP TO PATIENT	
CITY	STATE / ZIP	HOME PHONE	

6. GUARDIAN (IF PATIENT IS UNDER 18)

NAME Last	First	DATE OF BIRTH / /	SEX ❑ Male ❑ Female
ADDRESS	APT	RELATIONSHIP TO PATIENT	
CITY	STATE / ZIP	HOME PHONE	

7. ADDITIONAL QUESTIONS (Check one answer for each question)

HOUSING STATUS	❑ Public Housing	❑ Not Homeless	❑ Doubling Up	❑ Shelter
	❑ Street	❑ Transitional	❑ Other	❑ Unknown/Unreported
MIGRANT WORKER STATUS	❑ Not a Farm Worker	❑ Migrant	❑ Seasonal	
IS AN INTERPRETER NEEDED FOR THIS PATIENT?	❑ Yes ❑ No			
RACE	❑ American Indian/Alaska Native	❑ Asian	❑ Black/African American	❑ Native Hawaiian
	❑ Other Pacific Islander	❑ White	❑ More than one race	❑ Declined to identify
ETHNICITY	❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑ Other/Unreported	

8. INSURANCE

DO YOU HAVE INSURANCE? (If yes, please show your insurance card to the front desk receptionist.)	❑ Yes ❑ No
WOULD YOU LIKE TO APPLY FOR OUR SLIDING FEE DISCOUNT PROGRAM?	❑ Yes ❑ No

9. RELEASE AND CONSENT SIGNATURE

CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to Neighborcare Health is currently correct, and I understand that any deliberate misrepresentation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the medical, mental health and dental staff to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my health problem(s). I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that the mental health care may be given by a Psychiatrist, Psychologist or other licensed staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is canceled by written notice to the Chief Medical/Dental Officer. The assignment and release authorizes Neighborcare Health to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. I hereby authorize any insurance carrier with whom I have a policy to pay directly any benefits of any policies of insurance to those health care providers who have rendered services to me. I agree to pay in full all charges that are not paid in full by assigned insurance.

SIGNATURE	RELATIONSHIP TO PATIENT	DATE / /