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 1–8.

1. PATIENT INFORMATION

NAME Last	First	Middle	Previous Last	Preferred First

SOCIAL SECURITY NUMBER	DATE OF BIRTH	BIRTH SEX	CURRENT GENDER
___ ___ ___ – ___ ___ – ___ ___ ___ ___	/ /	❑ Male ❑ Female	❑ Male ❑ Female ❑ X

GENDER IDENTITY DETAIL	❑ Additional Gender or Other_____		❑ Choose not to Disclose
	❑ Female	❑ Female to Male	❑ Gender Queer
	❑ Male	❑ Male to Female	
SEXUAL ORIENTATION	❑ Bisexual	❑ Choose not to Disclose	❑ Don't Know
	❑ Lesbian, Gay or Homosexual	❑ Something Else _____	❑ Straight or Heterosexual
PREFERRED PRONOUN	❑ Unknown	❑ Declined to answer	❑ He, Him, His ❑ They, Them, Theirs
	❑ Other	❑ She, Her, Hers	❑ Ze, Hir

MAILING ADDRESS	APT	SECONDARY ADDRESS (if different)	APT

CITY	STATE	ZIP	CITY	STATE	ZIP

MARITAL STATUS (Check one)	❑ Single	❑ Married	❑ Partner
	❑ Legally Separated	❑ Divorced	❑ Widowed
WHAT IS YOUR PREFERRED LANGUAGE?			
ARE YOU A UNITED STATES VETERAN?	❑ Yes ❑ No	ARE YOU A SMOKER?	❑ Yes ❑ No

CONTACT INFORMATION

PREFERRED PHONE ❑ Home ❑ Cell ❑ Day	PERSONAL E-MAIL ADDRESS
SECONDARY PHONE ❑ Home ❑ Cell ❑ Day	NOTIFICATION PREFERENCE (choose one)
	❑ Text to cell ❑ Voice reminder/phone call to cell ❑ Phone call to home
	❑ Email to Patient Portal ❑ Opt out

2. PATIENT DEMOGRAPHICS

ARE YOU DISABLED OR HANDICAPPED?	WHICH BEST DESCRIBES YOUR HOUSEHOLD?
❑ Yes ❑ No	❑ Individual ❑ Single Female ❑ Single Male ❑ Two Parents ❑ Unknown
ARE YOU ACTIVELY SERVING IN THE US MILITARY?	IF YOU ARE RELATED TO SOMEONE WHO HAS SERVED OR IS IN THE US MILITARY, HOW ARE YOU RELATED?
❑ Yes ❑ No	❑ child of ❑ spouse/partner ❑ other dependent relative

3. PRIVACY NOTICE

I hereby acknowledge I have received Neighborcare Health's Notice of Privacy Practices. I understand Neighborcare Health may contact me about appointment reminders, test results, treatment options or other health related benefits and services via phone call, text message, e-mail, or voicemail.	Initials

4. EMERGENCY CONTACT

LAST NAME	FIRST NAME	DATE OF BIRTH	SEX
		/ /	❑ Male ❑ Female

ADDRESS	APT	RELATIONSHIP TO PATIENT

CITY	STATE	ZIP	PHONE

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

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Continued from reverse.

5. PARENT/GUARDIAN (IF PATIENT IS UNDER 18)

PARENT/GUARDIAN'S LAST NAME	PARENT/GUARDIAN'S FIRST NAME	DATE OF BIRTH / /	SEX ❑ Male ❑ Female
MAILING ADDRESS	APT	RELATIONSHIP TO PATIENT ❑ Parent ❑ Guardian ❑ Other	
CITY	STATE / ZIP	PHONE	

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

ARE YOU HOMELESS OR IN A TEMPORARY SHELTER?	❑ Doubling Up ❑ Not Homeless ❑ Other ❑ Permanent Supportive Housing ❑ Public Housing ❑ Shelter ❑ Street ❑ Transitional	
MIGRANT WORKER STATUS	At any point in the past two years, has seasonal or migrant farm work been your or you family's main source of income?	❑ No Farm Work ❑ Yes, Migrant Farm Work ❑ Yes, Seasonal Farm Work
DO YOU USE AN INTERPRETER?	❑ Yes ❑ No	
WHAT IS YOUR RACE OR FAMILY BACKGROUND?	❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian ❑ Other Pacific Islander ❑ White ❑ More than one race ❑ Declined to identify	
ARE YOU HISPANIC OR HISPANIC-LATINO?	❑ Yes, Hispanic or Latino ❑ Not Hispanic or Latino	
INCOME	What is your household's monthly gross income?	$ PER MONTH
TOTAL NUMBER IN HOUSEHOLD	Number of family members reported on federal income tax return?	
WOULD YOU LIKE TO APPLY FOR OUR SLIDING FEE DISCOUNT PROGRAM?		❑ Yes ❑ No

7. INSURANCE

DO YOU HAVE INSURANCE? (If yes, please show your insurance card to the front desk receptionist.)	❑ Yes ❑ No

8. 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 / /

HOW DID YOU HEAR ABOUT NEIGHBORCARE HEALTH? (mark all that apply)	❑ Friends or family ❑ Insurance ❑ Online search (Google) ❑ Other non-Neighborcare provider ❑ Convenient location/close to home ❑ Other community group or program ❑ Social media (Facebook, Twitter, Instagram) ❑ Ads (billboard, bus, newspaper) ❑ School ❑ Other