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 1–4.

1. PATIENT INFORMATION AND DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE NAME	PREVIOUS LAST	PREFERRED FIRST

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

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

MAILING ADDRESS	APT

CITY	STATE	ZIP

PREFERRED PHONE ❑ Home ❑ Mobile ❑ Work	PERSONAL E-MAIL ADDRESS
___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	
SECONDARY PHONE ❑ Home ❑ Mobile ❑ Work	APPOINTMENT NOTIFICATION PREFERENCE (choose one)
___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	❑ Text ❑ Phone Call ❑ MyChart

ARE YOU HISPANIC OR HISPANIC-LATINO?	❑ Yes, Hispanic or Latino	❑ Not Hispanic or Latino	
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 A UNITED STATES VETERAN?	❑ Yes ❑ No		
WHO IS YOUR EMPLOYER?			
WHAT IS YOUR EMPLOYMENT STATUS?	❑ Child	❑ Full-Time	❑ Not Employed
	❑ Part-Time	❑ Retired	❑ Seasonal
	❑ Student – Full Time	❑ Student – Part Time	
	❑ Active Military Duty	❑ Self Employed	
HOW WOULD YOU RATE YOUR ENGLISH FLUENCY?	❑ Excellent	❑ Very Good	❑ Good
	❑ Not Good	❑ Not at all	
WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?			

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

PATIENT REGISTRATION FORM

neighborcare health

Continued from reverse.

2. EMERGENCY CONTACT

LAST NAME	FIRST NAME		RELATIONSHIP TO PATIENT
ADDRESS			APT
CITY	STATE	ZIP	PHONE ❑ Home ❑ Mobile ❑ Work
			__ __ __ – __ __ __ – __ __ __ __

3. INSURANCE

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

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

INCOME	What is your household's monthly gross income? $_____	
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	
ARE YOU LIVING HOMELESS OR IN A TEMPORARY SHELTER?	❑ At risk for homelessness ❑ Currently not homeless, was in the last 12 months ❑ Homeless unknown shelter ❑ Living in shelter ❑ Living with others	❑ Not homeless ❑ Permanent supportive housing ❑ Single occupancy hotel ❑ Street, camp, bridge ❑ Transitional housing
MIGRANT/SEASONAL WORK STATUS	❑ Migrant ❑ Neither ❑ Seasonal	
HOW DID YOU HEAR ABOUT NEIGHBORCARE HEALTH? (MARK ALL THAT APPLY)	❑ Friends or family ❑ Other non-Neighborcare provider ❑ Other community group or program ❑ Ads (billboard, bus, newspaper)	❑ Insurance ❑ Convenient location/close to home ❑ Social media (Facebook, Twitter, Instagram) ❑ School
		❑ Online search (Google) ❑ Other