

PATIENT REGISTRATION FORM



Welcome! We are glad to be your health care partner. We collect the information below in order to provide you the best care.

PATIENT INFORMATION AND DEMOGRAPHICS						
LAST NAME		FIRST NAME	MIDDLE NAME	PREVIOUS LAST	PREFERRED FIRST	
SOCIAL SECURITY NUMBER ____ - ____ - ____		DATE OF BIRTH ____ / ____ / ____ MONTH DATE YEAR		LEGAL SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary		
MAILING ADDRESS				APT		
CITY			STATE	ZIP		
PREFERRED PHONE <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work ____ - ____ - ____			We will use this number for outreach and appointment reminders			
SECONDARY PHONE <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work ____ - ____ - ____						
GENDER IDENTITY		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Questioning	<input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Nonbinary/Gender Queer	<input type="checkbox"/> Other _____ <input type="checkbox"/> Choose not to disclose		
SEX ASSIGNED AT BIRTH		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Choose not to disclose		
SEXUAL ORIENTATION		<input type="checkbox"/> Straight <input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian <input type="checkbox"/> Queer	<input type="checkbox"/> Bisexual <input type="checkbox"/> Pansexual	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose	
PREFERRED PRONOUN		<input type="checkbox"/> She, Her, Hers <input type="checkbox"/> He, Him, His	<input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Other:	<input type="checkbox"/> Choose not to disclose		
ARE YOU HISPANIC OR LATINO?		<input type="checkbox"/> Yes, Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Choose not to disclose		
WHAT IS YOUR RACE OR FAMILY BACKGROUND?		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> More than one race	<input type="checkbox"/> Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to identify	<input type="checkbox"/> Black/African American <input type="checkbox"/> White		
ARE YOU A U.S. VETERAN?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
IF YOU ARE THE PATIENT, PLEASE LIST AN EMERGENCY CONTACT. We will contact this person if we are unable to reach you, but will not share health information. If the patient is a minor under 18 years old, please list the legal guardian.		LAST NAME		FIRST NAME		
		RELATIONSHIP TO PATIENT		PHONE <input type="checkbox"/> HOME <input type="checkbox"/> MOBILE <input type="checkbox"/> WORK ____ - ____ - ____		
		ADDRESS			APT	
		CITY		STATE	ZIP	
		Is this person allowed to verbally communicate* with the health care team on your behalf (are they involved in your care, your health care proxy, or your legal guardian)? *Excludes confidential services				

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Continued from reverse.

DO YOU OR A FAMILY MEMBER WORK FOR NEIGHBORCARE HEALTH?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
WHAT IS YOUR EMPLOYMENT STATUS?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal	<input type="checkbox"/> Child <input type="checkbox"/> Not Employed <input type="checkbox"/> Active Military Duty	<input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student
WHAT IS YOUR PREFERRED LANGUAGE?			
DO YOU NEED AN INTERPRETER?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
MYCHART ENROLLMENT	Do you want to sign up for MyChart, which will give you online access to your lab results and electronic communication with your care team?		<input type="checkbox"/> Yes <input type="checkbox"/> No
INSURANCE			
DO YOU HAVE INSURANCE?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
PLEASE LIST INSURANCE COVERAGE INFORMATION	NAME OF INSURANCE		EFFECTIVE DATE
	GROUP PLAN NUMBER	MEMBER ID #	
	SUBSCRIBER/POLICY HOLDER NAME	SUBSCRIBER DATE OF BIRTH	
ARE YOU INTERESTED IN OUR SLIDING FEE DISCOUNT PROGRAM?	We offer a sliding fee discount if you do not have health insurance or need help paying for expenses that health insurance does not cover. Eligibility for the program and the minimum fee is based on your family size and income. For more information and to apply, would you like to meet with one of our eligibility specialists?		<input type="checkbox"/> Yes <input type="checkbox"/> No
ADDITIONAL QUESTIONS (Answer for patient or, if patient is a minor, please answer for legal guardian.)			
YEARLY OR MONTHLY INCOME	What is your household's annual (yearly) gross income?	\$	If easier to calculate, what is your household's monthly income? \$
TOTAL NUMBER IN HOUSEHOLD	Number of family members reported on federal income tax return:		
ARE YOU HOMELESS OR IN A TEMPORARY SHELTER?	<input type="checkbox"/> Not Homeless <input type="checkbox"/> Doubling Up <input type="checkbox"/> Other <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional		
MIGRANT/SEASONAL WORK 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?		<input type="checkbox"/> No Farm Work <input type="checkbox"/> Yes, Migrant Farm Work <input type="checkbox"/> Yes, Seasonal Farm Work
HOW DID YOU HEAR ABOUT NEIGHBORCARE HEALTH? (Mark all that apply)	<input type="checkbox"/> Friends or family <input type="checkbox"/> Insurance <input type="checkbox"/> Online search (Google) <input type="checkbox"/> Other non-Neighborcare provider <input type="checkbox"/> Convenient location/close to home <input type="checkbox"/> Other community group or program <input type="checkbox"/> Social media (Facebook, Twitter, Instagram) <input type="checkbox"/> Ads (billboard, bus, newspaper) <input type="checkbox"/> School <input type="checkbox"/> Other		