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.

PATIENT INFORMATION AND DEMOGRAPHICS			TODAY'S DATE	__ __ / __ __ / __ __
LAST NAME	FIRST NAME	MIDDLE NAME	PREVIOUS LAST	PREFERRED FIRST
SOCIAL SECURITY NUMBER __ __ __ – __ __ – __ __ __ __	DATE OF BIRTH __ __ / __ __ / __ __ __ __ MONTH DAY YEAR	LEGAL SEX ❑ Male ❑ Female ❑ Nonbinary		
MAILING ADDRESS		APT		
CITY	STATE	ZIP		
PREFERRED PHONE ❑ Home ❑ Mobile ❑ Work __ __ __ – __ __ __ – __ __ __ __	We will use this number for outreach and appointment reminders			
SECONDARY PHONE ❑ Home ❑ Mobile ❑ Work __ __ __ – __ __ __ – __ __ __ __	E-MAIL ADDRESS			

GENDER IDENTITY	❑ Female ❑ Male ❑ Questioning	❑ Transgender Male to Female ❑ Transgender Female to Male ❑ Nonbinary/Gender Queer		❑ Other _____ ❑ Choose not to disclose
SEX ASSIGNED AT BIRTH	❑ Male	❑ Female	❑ Other:_____	❑ Choose not to disclose
SEXUAL ORIENTATION	❑ Asexual ❑ Pansexual	❑ Bisexual ❑ Queer	❑ Gay ❑ Straight	❑ Lesbian ❑ Something else	❑ Omnisexual ❑ Choose not to disclose
PRONOUNS	❑ She, Her, Hers ❑ He, Him, His		❑ They, Them, Theirs ❑ Patient's name	❑ Choose not to disclose ❑ Other _____
ARE YOU HISPANIC OR LATINO?	❑ Yes, Hispanic or Latino		❑ Not Hispanic or Latino	❑ Choose not to disclose
WHAT IS YOUR RACE OR FAMILY BACKGROUND?	❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ More than one race		❑ Asian ❑ Other Pacific Islander ❑ Declined to identify	❑ Black/African American ❑ White
ARE YOU A U.S. VETERAN?	❑ Yes ❑ 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 ❑ HOME ❑ MOBILE ❑ WORK __ __ __ – __ __ __ – __ __ __ __	
	ADDRESS	APT	DATE OF BIRTH __ __ / __ __ / __ __ __ __ MONTH DAY YEAR
	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*		❑ Yes ❑ No

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

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Continued from reverse.

DO YOU OR A FAMILY MEMBER WORK FOR NEIGHBORCARE HEALTH?	❑ Yes ❑ No		
WHAT IS YOUR EMPLOYMENT STATUS?	❑ Full Time ❑ Part Time ❑ Seasonal	❑ Child ❑ Not Employed ❑ Active Military Duty	❑ Self Employed ❑ Retired ❑ Student
WHAT IS YOUR PREFERRED LANGUAGE?			
DO YOU NEED AN INTERPRETER?	❑ Yes ❑ 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?		❑ Yes ❑ No

INSURANCE

DO YOU HAVE INSURANCE?	❑ Yes ❑ 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 need help paying for health care expenses. All patients are able to apply for this program. Eligibility for the program and the minimum fee is based on your household size and income. For more information and to apply, would you like to meet with one of our eligibility specialists?		❑ Yes ❑ 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 household members reported on federal income tax return:			
ARE YOU HOMELESS OR IN A TEMPORARY SHELTER?	❑ At Risk for Homelessness ❑ Child at Risk for Homelessness ❑ Currently not Homeless, was in last 12 months ❑ Homeless Unknown Shelter	❑ Living in Shelter ❑ Living with Others ❑ Not Homeless ❑ Permanent Supportive Housing	❑ Hotel ❑ Street, Camp, Bridge ❑ Transitional Housing ❑ Veteran at Risk for Homelessness	
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?		❑ No Farm Work ❑ Yes, Migrant Farm Work ❑ Yes, Seasonal Farm Work	
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	