

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			TODAY'S DATE	__ / __ / __	
LAST NAME	FIRST NAME	MIDDLE NAME	PREVIOUS LAST	PREFERRED FIRST	
SOCIAL SECURITY NUMBER __ - __ - ____		DATE OF BIRTH __ / __ / ____ MONTH DAY 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 __ - __ - ____		E-MAIL ADDRESS			
GENDER IDENTITY	<input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Other _____ <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Questioning <input type="checkbox"/> Nonbinary/Gender Queer				
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"/> Asexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Omnisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Queer <input type="checkbox"/> Straight <input type="checkbox"/> Something else <input type="checkbox"/> Choose not to disclose				
PRONOUNS	<input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> He, Him, His <input type="checkbox"/> Patient's name <input type="checkbox"/> Other _____				
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"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Choose not to disclose				
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	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				<input type="checkbox"/> Yes <input type="checkbox"/> No

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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 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?		<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 household members reported on federal income tax return:		
ARE YOU HOMELESS OR IN A TEMPORARY SHELTER?	<input type="checkbox"/> At Risk for Homelessness <input type="checkbox"/> Child at Risk for Homelessness <input type="checkbox"/> Currently not Homeless, was in last 12 months <input type="checkbox"/> Homeless Unknown Shelter	<input type="checkbox"/> Living in Shelter <input type="checkbox"/> Living with Others <input type="checkbox"/> Not Homeless <input type="checkbox"/> Permanent Supportive Housing	<input type="checkbox"/> Hotel <input type="checkbox"/> Street, Camp, Bridge <input type="checkbox"/> Transitional Housing <input type="checkbox"/> 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?		<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"/> Other non-Neighborcare provider <input type="checkbox"/> Other community group or program <input type="checkbox"/> Ads (billboard, bus, newspaper)	<input type="checkbox"/> Insurance <input type="checkbox"/> Convenient location/close to home <input type="checkbox"/> Social media (Facebook, Twitter, Instagram) <input type="checkbox"/> School	<input type="checkbox"/> Online search (Google) <input type="checkbox"/> Other