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	LEGAL SEX
__ __ __ – __ __ – __ __ __ __	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	❑ Male ❑ Nonbinary ❑ Female ❑ X

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 ❑ Other: _____	❑ Transgender Male to Female ❑ Transgender Female to Male ❑ Nonbinary	❑ Gender Queer ❑ Two Spirit ❑ Choose not to disclose
SEX ASSIGNED AT BIRTH	❑ Male ❑ Female ❑ Intersex ❑ Other: _____ ❑ Choose not to disclose		
SEXUAL ORIENTATION	❑ Asexual ❑ Bisexual ❑ Gay ❑ Lesbian ❑ Omnisexual ❑ Pansexual ❑ Queer ❑ Straight ❑ Something else ❑ Choose not to disclose		
PRONOUNS	❑ She, Her, Hers ❑ He, Him, His	❑ They, Them, Theirs ❑ Patient's name	❑ Choose not to disclose ❑ Other _____
WHAT IS YOUR ETHNICITY?	❑ Cuban ❑ Puerto Rican	❑ Mexican, Mexican American, Chicano/a ❑ Another Hispanic, Latino/a or Spanish Origin	❑ Not Hispanic or Latino/a ❑ Choose not to disclose
WHAT IS YOUR RACE OR FAMILY BACKGROUND? Check all that apply.	❑ Alaskan Native ❑ Black/African American ❑ Guamanian or Chamorro ❑ Native Hawaiian ❑ Other Asian ❑ Choose not to disclose	❑ American Indian ❑ Chinese ❑ Japanese ❑ Samoan ❑ Other Pacific Islander	❑ Asian Indian ❑ Filipino ❑ Korean ❑ Vietnamese ❑ White
DO YOU LIVE WITH A DISABILITY? If yes, check all that apply:	❑ Yes ❑ No ❑ Communication disability ❑ Social relationships disability ❑ Vision disability	❑ Learning disability ❑ Mental health disability ❑ Thinking disability	❑ Movement disability ❑ Hearing disability ❑ Remembering disability
HAVE YOU SERVED IN THE UNITED STATES MILITARY, ARMED FORCES, OR UNIFORMED SERVICES?			❑ 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

This form continues on reverse. Please complete all sections.

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Continued from reverse.

EMERGENCY CONTACT (continued)	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
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:			
HOUSING STATUS	❑ Not Homeless ❑ Currently not Homeless, was in last 12 months ❑ Permanent Supportive Housing	❑ Living with Others ❑ Living in Shelter ❑ Living in Transitional Housing	❑ Hotel ❑ Street, Camp, Bridge, Vehicle ❑ Homeless, Shelter Unknown	
MIGRANT/SEASONAL WORK STATUS	At any point in the past two years, has seasonal or migrant farm work been your or your family's main source of income?		❑ No Farm Work ❑ Yes, Migrant Farm Work ❑ Yes, Seasonal Farm Work	