

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
SOCIAL SECURITY NUMBER		DATE OF BIRTH		LEGAL SEX	
____ - ____ - ____		____ / ____ / ____ MONTH DAY YEAR		<input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> Female <input type="checkbox"/> X	
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"/> Woman <input type="checkbox"/> Transgender Woman <input type="checkbox"/> Gender Queer <input type="checkbox"/> Man <input type="checkbox"/> Transgender Man <input type="checkbox"/> Two Spirit <input type="checkbox"/> Questioning <input type="checkbox"/> Nonbinary <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____			
SEX ASSIGNED AT BIRTH		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <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 _____			
WHAT IS YOUR ETHNICITY?		<input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Not Hispanic or Latino/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Choose not to disclose			
WHAT IS YOUR RACE OR FAMILY BACKGROUND? Check all that apply.		<input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Choose not to disclose			
DO YOU LIVE WITH A DISABILITY? If yes, check all that apply:		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Communication disability <input type="checkbox"/> Learning disability <input type="checkbox"/> Movement disability <input type="checkbox"/> Social relationships disability <input type="checkbox"/> Mental health disability <input type="checkbox"/> Hearing disability <input type="checkbox"/> Vision disability <input type="checkbox"/> Thinking disability <input type="checkbox"/> Remembering disability			
HAVE YOU SERVED IN THE UNITED STATES MILITARY, ARMED FORCES, OR UNIFORMED SERVICES?					<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
	CITY		STATE		ZIP

This form continues on reverse. Please complete all sections.

PATIENT REGISTRATION FORM



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)? <i>*Excludes confidential services</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No
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:			
HOUSING STATUS	<input type="checkbox"/> Not Homeless <input type="checkbox"/> Currently not Homeless, was in last 12 months <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Living with Others <input type="checkbox"/> Living in Shelter <input type="checkbox"/> Living in Transitional Housing <input type="checkbox"/> Hotel <input type="checkbox"/> Street, Camp, Bridge, Vehicle <input type="checkbox"/> 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?			<input type="checkbox"/> No Farm Work <input type="checkbox"/> Yes, Migrant Farm Work <input type="checkbox"/> Yes, Seasonal Farm Work