REGISTRATION FORM

Choose an item.

Today's Date:	**PCP:**

PATIENT INFORMATION

Patient's Legal Last Name:	**First:**	**Middle:**

Previous Names Used/Alias:	**Birth Date:** / /	**Age:**	**Social Security #:**

Sex at Birth: ❑Male ❑Female ❑Other ❑ Choose not to disclose ❑Intersex ❑Not recorded on birth certificate

Home Phone:	**Cell Phone:**	**Work Phone:**

Mailing Address:	**City:**	**State:**	**Zip:**

E-Mail Address:

Race:
❑Alaskan Native
❑Pacific Islander
❑Native Hawaiian
❑Asian
❑White
❑American Indian
❑Black or African American
❑Unknown
❑Choose not to disclose

Ethnicity:
❑Hispanic ❑Not Hispanic
❑Unknown
❑Choose not to disclose

Sexual Orientation:
❑ Asexual
❑ Bisexual
❑ Lesbian or Gay
❑ Omnisexual
❑ Pansexual
❑ Straight (not lesbian or gay)
❑ Queer
❑ Something else
Don't know
❑ Choose not to disclose

Gender Identity:
❑ Female
❑ Male
❑ Transgender Female / Male-to-Female
❑ Transgender Male / Female-to-Male
❑ Non-Binary/Genderqueer
❑Questioning
❑Two Spirit
❑Choose not to disclose
❑Other:_____

Preferred Pronoun:
❑ she/her/hers
❑ he/him/his
❑ they/them/theirs
❑ patient's name
❑ Ze/hir/hirs
❑ ey/em/eirs
❑ xe/xem/xyrs
❑ Decline to answer
❑Unknown
❑Other: _____

EMPLOYMENT STATUS

Employment Status:
❑ Child
❑Full time
❑Part time
❑Not employed
❑On Active Military Duty
❑Retired
❑Seasonal
❑Self-Employed
❑Student Full-Time
❑Student Part-Time
❑Unemployed due to disability
❑Unknown

Veteran/Military Status
❑Active Duty
❑Inactive Duty
❑No previous experience
❑Reservist
❑Uncollected
❑Veteran

Number of Family Members:	**Monthly Income (before taxes) $**

LANGUAGE

What language do you speak at your home:	**Interpreter Needed:** ❑Yes ❑No
❑English ❑Spanish ❑Other: _____	**Preferred:** ❑Male ❑Female ❑No Preference

(turn page over to finish reading and sign this registration form)

RESPONSIBLE PARTY

If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Parent/Legal Guardian Responsible for Bill:	**Birth Date:** / /	**Social Security # of Parent/Legal Guardian:**	
Mailing Address: ❑ Same as above	**City:**	**State:**	**Zip:**
Phone Number:	❑Home ❑Mobile ❑Work		

ADDITIONAL INFORMATION

Homeless Status:

- ❑Not Homeless
- ❑At Risk for Homeless
- ❑Transitional Housing
- ❑Permanent Supportive Housing
- ❑Child at Risk for Homeless
- ❑Living with Others
- ❑Homeless, Unknown Shelter
- ❑Living in Shelter
- ❑Veteran at Risk for Homeless
- ❑Single Occupancy Hotel
- ❑Street, Camp, Bridge
- ❑Currently Not Homeless, Was in the Last 12 Months

Farm Work Recognition: Are you or someone in your household involved in a type of farm work that may include: soil prepping, planting, picking, cleaning, sorting, packing, Christmas tree farming?

❑Yes ❑No

❑ Migrant – You or a member of your household has established a temporary home in order to do farm work
❑ Seasonal – You or a member of your household do farm work that only happens at certain times throughout the year

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neighborhood Health Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

FOR OFFICE USE ONLY

Initials for Special Confidentiality:_____ Screen By: _____ Total Income: $ _____

TITLE X: Clients pay _____ % per sliding fee scale for non-FPEP covered service.

Address Verification: □ Yes Date/Initials_____ □ Patient declined confidentiality