REGISTRATION FORM

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:** ❑M ❑F ❑Other
Home Phone:	**Cell Phone:**		**Work Phone:**	
Mailing Address:	**City:**	**State:**	**Zip:**	
E-Mail Address:	**Preferred Communication:** ❑ Do not contact ❑ Mail ❑ Phone ❑email via MyChart ❑ No preference			

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

Ethnicity:
❑Hispanic ❑Not Hispanic
❑Unknown

Sexual Orientation:
❑Lesbian or gay
❑ Straight (not lesbian or gay)
❑ Bisexual
❑ Something else_____
❑ Don't know
❑Choose not to disclose

Gender Identity:
❑Female
❑Male
❑ Transgender Female / Male-to-Female
❑ Transgender Male / Female-to-Male
❑Other: _____
❑Choose not to disclose

Preferred Pronoun:
❑ she/her/hers
❑ he/him/his
❑ they/them/theirs
❑ patient's name
❑ decline to answer
❑ unknown

IN CASE OF EMERGENCY			
Name:	**Relationship to patient:**	**Phone Number:** ❑Home ❑Mobile ❑Work	**Ok to leave voicemail:** ❑Yes ❑No

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

Are you a Veteran?
❑Yes ❑No

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

LANGUAGE

What language do you speak at your home:
❑English ❑Spanish ❑Other: _____

Interpreter Needed: ❑Yes ❑No
Preferred: ❑Male ❑Female ❑No Preference

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			

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

ADDITIONAL INFORMATION

Homeless Status:

- ❑Not Homeless
- ❑At Risk for Homeless
- ❑Transitional Housing
- ❑Living with Others
- ❑Homeless, Unknown Shelter
- ❑Living in Shelter
- ❑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