Neighborhood Health
Your Health. Our Passion.

OFFICE USE ONLY	
PATIENT #:	
SLIDE TYPE:	

Registration Form

Patient Information

Last Name **First Name** **Middle Initial**

Previous Name **Social Security Number (optional)**

Street Address **Apt #** **( ) Home Phone Number** **( ) Mobile Phone Number**

City **State** **Zip Code** **Email Address**

Date of Birth ____/____/_____ **Sex at Birth:** ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widowed

Employer Name: _____

Employment Status: ❑ Full-time ❑ Part-time ❑ Not employed ❑ Self Employed ❑ Retired ❑ On-active military duty ❑ Unknown

Student Status: ❑ Full-time ❑ Part-time ❑ Not a Student

Emergency Contact **Relationship to the Patient** **( ) Phone Number**

Do you have Legal Guardian or Healthcare Proxy? ❑ Yes ❑ No Do you have Advance Directives? ❑ Yes ❑ No

Race: ❑ African American ❑ White ❑ Asian ❑ Hawaiian ❑ American Indian/Alaska Native ❑ Pacific Islander ❑More than one race

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Refuse to report

Preferred Language: ❑ English ❑ Spanish ❑ Urdu ❑ Amharic ❑ Arabic ❑ Hindi ❑ Farsi ❑ French ❑ Other

Do you have Special Communication Needs such as Sign Language? ❑ Yes ❑ No Explain:_____

Are you a seasonal worker? ❑ Yes ❑ No **Are you a migrant worker?** ❑ Yes ❑ No **Are you a veteran?** ❑ Yes ❑ No

Are you Homeless: ❑ Street ❑ Doubling up (living with more than one family or more than four individuals) ❑ Transitional ❑ Shelter ❑ Unknown ❑ Other specify: _____

Referred by: ❑ Doctor / Medical Facility ❑ Shelter ❑ Outreach Event ❑ Health/Resource Fair ❑ School/Head Start

❑ Family / Friend Other:_____

Sexual Orientation:
- ❑ Lesbian or Gay
- ❑ Straight
- ❑ Bisexual
- ❑ Something else
- ❑ Don't know
- ❑ Choose not to disclose

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

Neighborhood Health
Your Health. Our Passion.

OFFICE USE ONLY	
PATIENT #:	
SLIDE TYPE:	

Registration Form

Responsible Party for paying bills ❑Self ❑ Another Person (*complete below*)

_____
(Last) *(First)* *(Middle Initial)*

Relation_____ Responsible Party D.O.B_____/____/_____

Pharmacy Preference

Name of Pharmacy:_____

Pharmacy Location/Number:_____

Insurance Information

Primary Insurance (if applicable):_____

Address:_____

Subscriber Number:_____ Co-Pay: $_____

Insured's Name:_____

Patient's Relationship to Insured:_____

Group Number:_____ Employer/Group Name:_____

Medicaid ID Number:_____

Secondary Insurance (if applicable):_____

Address:_____

Subscriber Number:_____ Co-Pay: $ _____

Group Number:_____ Employer/Group Name:_____

The above information is true to the best of my knowledge.

_____ _____
Patient or Parent/Legal Guardian **Date**

_____ _____
Relationship to Patient **Witness Signature**