Neighborhood Health

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

Race:

❑ Asian
(Please specify)
- Asian Indian
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

❑ Black/African American

❑ American Indian/Alaska Native

❑ Native Hawaiian/ Other Pacific Islander (Please specify)
- Native Hawaiian
- Other Pacific Islander
- Guamanian or Chamorro
- Samoan

❑ White

❑ More than one race

❑ Choose not to disclose

Ethnicity:

❑ Hispanic/Latino
(Please specify)
- Mexican/Chicano/ Mexican American
- Puerto Rican
- Cuban
- Another Hispanic/ Latino/Spanish origin

❑ Non-Hispanic/Latino

❑ Choose not to disclose

( )

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

Preferred Language: ❑ English ❑ Spanish ❑ Amharic ❑ Urdu/Hindi ❑ Arabic ❑ Dari/Farsi ❑ Bengali ❑ 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: ____________________

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

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

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:____

What is your current estimate household income?

(Include all sources of income, such as wages, social security, disability, etc.)

$____________________ ❑ per week ❑ per month ❑ per year

❑ Choose not to disclose

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

____ ________________________

Patient or Parent/Legal Guardian **Date**

____ ________________________

Relationship to Patient **Witness Signature**