

Patient Registration Form



Patient Information (Please print clearly)				
Legal Name*	Last	First	Middle Initial	Name used:
Legal Sex (please check one)* <input type="checkbox"/> Female <input type="checkbox"/> Male				Pronouns:
<i>*While Outer Cape Health Services recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.</i>				
Date of Birth (mm/dd/yyyy) _____ / _____ / _____			Social Security #	

Contact Information			
<i>Your answers to the following questions will help us reach you quickly and discreetly with important information.</i>			
Home Phone	Cell Phone	Work Phone	Best number to use to leave results & messages?
Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other:
Mailing Address		City	State Zip Code
Address (if different from above)		City	State Zip Code
Email address		Would you like to register for the Patient Portal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation		Employer/School Name	
Are you covered under school or employer's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact's Name		Phone Number	Relationship to you
<i>If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.</i>			
Parent/Guardian Name		Phone Number	Relationship to you

Preferred Pharmacy	
Pharmacy Name _____	Address _____

Insurance Information			
Medical	Plan Name	Subscriber #	Insured Name
Secondary	Plan Name	Subscriber #	Insured Name
Vision	Plan Name	Subscriber #	Insured Name
Dental	Plan Name	Subscriber #	Insured Name

Permission to Speak/Share Information		
<p>I authorize disclosure of my healthcare information to the individuals listed below. I understand that this authorization is voluntary I understand that one disclosed by Outer Cape Health Services to such person(s), we can no longer ensure that the confidentiality of the information. I understand that this authorization will remain in effect until Outer Cape Health Services receives written notice from me to cancel it.</p>		
Name	Relationship	Phone Number

Demographic Information			
<p><i>This information is for demographic purposes only and will not affect your care.</i> As a Federally Qualified Health Center, Outer Cape Health is required to collect demographic information regarding the patients we serve. The information you provide is confidential.</p>			
1) What is your annual income? \$ _____ <input type="checkbox"/> No income How many people (including you) does your income support?	2) Employment Status <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Student full-time <input type="checkbox"/> Student part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____	3) Racial Group(s) (check all that apply) <input type="checkbox"/> African American / Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Native American / Alaskan Native / Native Hawaiian <input type="checkbox"/> Pacific Islander	4.) Ethnicity <input type="checkbox"/> Hispanic/Latino/Latina <input type="checkbox"/> Not Hispanic/Latino/Latina
5) Preferred Language (choose one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Portuguese <input type="checkbox"/> Hebrew <input type="checkbox"/> Other _____	6) Do you think of yourself as: <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose	7) Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____	8.) Veteran Status <input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran
9.) What is your gender? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Genderqueer or not exclusively male or female <input type="checkbox"/> Choose not to disclose	10) What was your sex assigned at birth? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to disclose	11) Do you identify as transgender or transsexual? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose	