CRESCENTCARE PATIENT REGISTRATION FORM

As a community health center, we are required to collect demographic information about our patients. We understand that it is personal information, and we appreciate that you support our data collection so that we may better serve our community. This information will become a part of your confidential medical record.

Legal Last Name + Suffix: ____________ **Legal First Name:** ____________ **MI:** ____

Chosen/Preferred Name (if different): ____________ **Email:** ____________

Mailing/Physical Address: ____________

City: ____________ **State:** ________ **Zip:** ______ **Phone Number:** ____________

Date of Birth: ___/___/___ **Social Security Number:** ______ - ______ - ______

Preferred Language: ____________ **Interpreter needed?** ☐ Yes ☐ No

ETHNIC GROUP	RACE	
☐ Non-Hispanic	☐ White	☐ Asian
☐ Hispanic or Latino/a	☐ Black/African American	☐ Asian Indian
☐ Mexican/Mexican American/Chicano/a	☐ Native Hawaiian	☐ Chinese
☐ Puerto Rican	☐ Guamanian or Chamorro	☐ Filipino
☐ Cuban	☐ Samoan	☐ Japanese
☐ Choose not to disclose	☐ Other Pacific Islander	☐ Korean
☐ Other ____________	☐ American Indian/Alaskan Native	☐ Vietnamese
	☐ Choose not to disclose	☐ Other Asian

Patient's Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them

Patient's Sex Assigned at Birth: ☐ Female ☐ Male

Patient's Sexual Orientation: ☐ Straight or Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Do not know ☐ Choose not to disclose ☐ Other ____________

Patient's Gender Identity: ☐ Cis Woman/Female ☐ Cis Man/Male ☐ Non-Binary/Genderqueer
☐ Transgender Man/Transgender Male/Transmasculine
☐ Transgender Woman/Transgender Female/Transfeminine
☐ Choose not to disclose ☐ Other ____________

U.S. Veteran/Military Status: ☐ Active Duty ☐ Inactive Duty ☐ Reservist ☐ Veteran ☐ Does not apply

Agricultural/Migrant Status: ☐ Migrant ☐ Seasonal ☐ Does not apply

Housing Status: ☐ Stable/Permanent ☐ Transitional ☐ Homeless ☐ Doubling Up ☐ Street ☐ Other

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CrescentCare
A Partnership for Life

Advanced Directive: **Do you have an advanced directive?** (A form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are unable to respond): ☐ Yes ☐ No

IF PATIENT IS AGE 17 OR UNDER; INFORMATION ABOUT PARENT(S) OR LEGAL GUARDIAN(S)

#1 Last Name: ____________ First Name: ____________ MI: ____

Relationship to Patient: ____________ Phone Number: ____________

Address (if different from patient): ____________

#2 Last Name: ____________ First Name: ____________ MI: ____

Relationship to Patient: ____________ Phone Number: ____________

Address (if different from patient): ____________

INSURANCE INFORMATION <u>OR</u> RESPONSIBLE PARTY

Plan Holder: ____________ DOB: ___/___/___ Relationship to Patient: ____________

Health Plan Name: ____________ Address: ____________

Name on Insurance Card: ____________ City/State/Zip: ____________

Sex on file with insurance plan: ____________

Member ID: ____________ Phone Number: ____________

Primary Care Physician: ____________ Preferred Pharmacy/Location: ____________

EMERGENCY CONTACT

Full Name: ____________ Relationship to Patient: ____________

Emergency Contact Telephone Number: ____________

ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

I authorize payment for all medical benefits to CrescentCare for professional service rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collection and reasonable attorney fees.

Patient/Guardian Signature: ____________ Date: ____________