Patient Registration Form

Outer Cape HEALTH SERVICES

Patient Information (Please print clearly in BLACK ink only)

Legal Name* Last	First	Middle Initial	**Name used:**

Legal Sex (please check one)* ☐ Female ☐ Male **Pronouns:**

**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.*

Date of Birth (mm/dd/yyyy) _____ / _____ / _____ **Social Security #**

Contact Information

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Cell Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Work Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Best number to use to leave results & messages?** ☐ Home ☐ Cell ☐ Work ☐ 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? ☐ Yes ☐ No

Occupation Employer/School Name

Are you covered under school or employer's insurance? ☐ Yes ☐ No

Emergency Contact's Name Phone Number Relationship to you

If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.

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

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.

Name	Relationship	Phone Number

Demographic Information

This information is for demographic purposes only and will not affect your care. 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.

1) What is your annual income?

$ _____

☐ No income

How many people (including you) does your income support?

2) Employment Status

☐ Employed full-time
☐ Employed part-time
☐ Student full-time
☐ Student part-time
☐ Retired
☐ Unemployed
☐ Other _____

3) Racial Group(s) (check all that apply)

☐ African American / Black
☐ Asian
☐ Caucasian / White
☐ Native American / Alaskan Native / Native Hawaiian
☐ Pacific Islander

4.) Ethnicity

☐ Hispanic/Latino/Latina
☐ Not Hispanic/ Latino/Latina

5) Preferred Language (choose one)

☐ English
☐ Spanish
☐ French
☐ Portuguese
☐ Hebrew
☐ Other _____

6) Do you think of yourself as:

☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else
☐ Don't know
☐ Choose not to disclose

7) Marital Status

☐ Married
☐ Partnered
☐ Single
☐ Divorced
☐ Other _____

8.) Veteran Status

☐ Veteran
☐ Not a Veteran

9.) What is your gender?

☐ Female
☐ Male
☐ Genderqueer or not exclusively male or female
☐ Choose not to disclose

10) What was your sex assigned at birth?

☐ Female
☐ Male
☐ Choose not to disclose

11) Do you identify as transgender or transsexual?

☐ Yes
☐ No
☐ Don't know
☐ Choose not to disclose