Patient Registration Form

Outer Cape HEALTH SERVICES

Patient Information (Please print clearly in BLACK ink only)

Legal Name* Last First Middle Initial

Preferred Name:

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

Mailing Address City State Zip Code

Address (if different from above) City State Zip Code

Please circle your primary phone number:

Home Phone	**Cell Phone**	**Work Phone**	**Communication Preferences**
( )	( )	( )	***Check all that apply:***
Ok to leave voicemail?	**Ok to leave voicemail?**	**Ok to leave voicemail?**	❑ Mail ❑ MyChart
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Email ❑ Primary Phone
			Appointment reminders default to text msg. Please check if you prefer phone calls. ❑

Email address

Would you like to sign up for MyChart? ❑ Yes ❑ No

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.

Marital Status

❑ Married ❑ Partnered ❑ Single ❑Divorced ❑Other_____

Ethnicity

- ❑ Hispanic/Latino/Latina
- ❑ Not Hispanic/ Latino/Latina
- ❑ Unknown

Racial Group(s) (check all that apply)

- ❑ Alaskan Native
- ❑ American Indian
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian
- ❑ Pacific Islander
- ❑ Unknown
- ❑ White

Veteran Status

- ❑ Active Duty
- ❑ Inactive Duty
- ❑ Not a Veteran
- ❑ Reservist
- ❑ Veteran

Preferred Language *(choose one)*

- ❑ English
- ❑ Spanish
- ❑ French
- ❑ Portuguese
- ❑ Other _____

Patient Name:_____ Date of Birth:_____

Patient Contacts

Emergency Contact's Name Phone Number Relationship

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

Parent/Guardian Name Phone Number Relationship

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

Employment

Employment Status

- ❑ Employed full-time
- ❑ Employed part-time
- ❑ Student full-time
- ❑ Other:_____

Occupation

Employer/School Name

Are you covered under school or employer's insurance?

❑ Yes ❑ No

Sexual Orientation & Gender Identification

Sexual Orientation

- ❑ Lesbian
- ❑ Gay
- ❑ Straight / heterosexual
- ❑ Bisexual
- ❑ Pansexual
- ❑ Choose not to disclose
- ❑ Asexual
- ❑ Omnisexual
- ❑ Queer
- ❑ Don't know
- ❑ Other

Gender Identity

- ❑ Female
- ❑ Male
- ❑ Transgender Female
- ❑ Transgender Male
- ❑ Genderqueer or non-binary
- ❑ Choose not to disclose
- ❑ Questioning
- ❑ Other

Sex assigned at birth.

- ❑ Female
- ❑ Male
- ❑ Intersex
- ❑ Choose not to disclose

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

Annual Demographic Form

Patient Name:_____ Date of Birth:_____

All patients must complete this form and update annually. As a federally qualified health center, we are required to obtain the information below. This information is for grant & reporting purposes only. No personally identifiable information is ever reported. The confidentiality of what you report below is protected by law.

Family Size:

How many people are in your family household? _____

Income:

Counting yourself, your spouse and all dependent children (those 18 years or younger who are still claimed as dependent on your federal tax return) what is your gross income (income before taxes) for your family?

$_____ **Select one:** ❑ Daily ❑ Weekly ❑ Monthly ❑ Annually

Homeless Status

Which best describes your housing/homeless status?

- ☐ At risk for homeless
- ☐ Child at risk for homeless
- ☐ Currently not homeless, but was in the last 12 months
- ☐ Living in a shelter
- ☐ Living with others
- ☐ Not homeless
- ☐ Permanent supportive housing
- ☐ Single occupancy hotel
- ☐ Street, camp, bridge
- ☐ In transitional housing
- ☐ Veteran at risk for homeless

Migrant/Seasonal Worker Status

Are you a migrant or seasonal agricultural worker? ❑ Seasonal ❑ Migrant ❑ Neither