# 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** ( ) **Ok to leave voicemail?** ❑ Yes ❑ No | **Cell Phone** ( ) **Ok to leave voicemail?** ❑ Yes ❑ No | **Work Phone** ( ) **Ok to leave voicemail?** ❑ Yes ❑ No | **Communication Preferences** ***Check all that apply:*** ❑ Mail ❑ MyChart ❑ 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

# Treatment, Payment and Data Agreement

Outer Cape HEALTH SERVICES

**Print Name:** _____ **Date of Birth:** _____

- I hereby give my consent and authorize Outer Cape Health Services to treat any medical or mental health condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.
- I understand that Outer Cape Health Services operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.
- I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.
- I authorize examination and treatment for this and all following medical or mental health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Outer Cape Health Services may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I certify that the above information is true and correct. I have received a copy of Outer Cape's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

**Patient Signature** _____ **Date** _____

**General Information:** Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

*Outer Cape Health is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Outer Cape Health, OCHIN supplies information technology and related services to Outer Cape Health and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Outer Cape Health with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.*

*The information in your medical record is confidential and is protected under both Federal and Massachusetts laws. Your written consent will be required for release of information except in those certain circumstances where consent is not legally required.*