Patient Registration Form

Outer Cape HEALTH SERVICES

Patient Information (Please print clearly in BLACK ink only)

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

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

Sexual Orientation & Gender Identification

Sex Assigned at Birth

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Not Recorded on Birth Certificate
- ☐ I don't know/am unsure of my sex at birth
- ☐ I choose not to answer
- ☐ Other _____

Legal Sex

- ☐ Male
- ☐ Female
- ☐ Non-Binary
- ☐ Other _____

Pronouns

- ☐ She/Her/Hers
- ☐ He/Him/His
- ☐ They/Them/Theirs
- ☐ Patient Name
- ☐ I choose not to answer
- ☐ My pronouns are not listed

Sexual Orientation

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Straight
- ☐ Omnisexual
- ☐ Pansexual
- ☐ Queer
- ☐ I don't know
- ☐ I choose not to answer
- ☐ Other _____

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Questioning
- ☐ Genderqueer or non-binary
- ☐ I choose not to answer
- ☐ Other _____

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:

☐ Mail ☐ MyChart ☐ Email ☐ 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

Patient Name _____ Date of Birth _____

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 _____

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

Ethnicity
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ I don't know/am not sure of my ethnicity
- ❑ I choose not to answer

Racial Group(s) (Check all that apply)

- ❑ American Indian or Alaskan Native
  Please Specify _____
- ❑ Asian
  Please Specify _____
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
  Please Specify _____
- ❑ White
- ❑ Other
  Please Specify _____
- ❑ I choose not to answer
- ❑ I do not know/am not sure of my race

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

Language

Preferred Spoken Language
- ❑ ASL
- ❑ English
- ❑ French
- ❑ Haitian Creole
- ❑ Spanish
- ❑ Portuguese
- ❑ I choose not to answer
- ❑ Other _____

Preferred Written Language
- ❑ English
- ❑ French
- ❑ Haitian Creole
- ❑ Spanish
- ❑ Portuguese
- ❑ I choose not to answer
- ❑ Other _____

Preferred Pharmacy

Pharmacy Name _____ **Address** _____

Patient Name _____ Date of Birth _____

Insurance Information	
Medical	Plan Name Subscriber # Subscriber Name DOB: Subscriber Address
Secondary	Plan Name Subscriber # Subscriber Name DOB: Subscriber Address
Vision	Plan Name Subscriber # Subscriber Name DOB: Subscriber Address

Disability

1. Are you deaf or do you have difficulty hearing?
   YES **NO** **I Choose Not to Answer** **I Don't Know/Am Not Sure**
2. Are you blind or do you have difficulty seeing?
   YES **NO** **I Choose Not to Answer** **I Don't Know/Am Not Sure**
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
   YES **NO** **I Choose Not to Answer** **I Don't Know/Am Not Sure**
4. Do you have difficulty walking or climbing stairs?
   YES **NO** **I Choose Not to Answer** **I Don't Know/Am Not Sure**
5. Do you have difficulty dressing or bathing?
   YES **NO** **I Choose Not to Answer** **I Don't Know/Am Not Sure**
6. Because of a physical, mental, or emotional condition, do you have difficulty doing errands?
   YES **NO** **I Choose Not to Answer** **I Don't Know/Am Not Sure**

Patient Signature _____ Date: _____