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

Emergency Contact Name	**Phone Number**	**Relationship to Patient**

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: _____