

New Patient Registration Form



PERSONAL INFORMATION				
First Name	MI	Last Name	Preferred or Chosen Name	
Date of Birth (MM/DD/YYYY)	Social Security Number		Legal Sex	
			☐ Male ☐ Female ☐ Nonbinary	
CONTACT AND ADDRESS INFORMATION				
Cell Phone	Home Phone		Email Address (please print clearly)	
How would you prefer that we contact you?		☐ Cell Phone ☐ Home Phone ☐ MyChart		
How would you like to receive a bill from PHC?		☐ Paperless (Text/Email) ☐ Mail		
What is your primary language?		Do you need an interpreter?		Hard of Hearing?
☐ English ☐ Other: _____		☐ Yes ☐ No ☐ ASL		☐ Yes ☐ No
Mailing Address	City		State	ZIP
Physical Address (if different from mailing address)	City		State	ZIP
Do you live in a group home or congregate care home?		☐ Yes ☐ No ☐ Choose not to answer		
Are you experiencing houselessness?		☐ Yes ☐ No ☐ Choose not to answer		
If not, are you worried about losing your housing?		☐ Yes ☐ No ☐ Choose not to answer		
If you are currently houseless, where do you sleep at night?	☐ On the street or in a car ☐ Doubling Up (Staying with friend or family) ☐ Shelter			
	☐ Transitional housing ☐ Permanent Supportive Housing ☐ Other			
ADDITIONAL INFORMATION				
<i>Our life experiences play an important role in our health and well-being. We ask you these questions so we can better understand your experience and give you the best care possible. Please answer what you feel comfortable answering. Thank you!</i>				
Marital Status?	☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Choose not to disclose			
Employment Status:	☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Migrant ☐ Seasonal ☐ Other: _____ ☐ Student ☐ Seasonal Agricultural Worker			
Are you employed in healthcare?	☐ Yes ☐ No	What is your religion?		
What was your sex assigned at birth?		What are your pronouns?		
☐ Female ☐ Male ☐ Intersex		☐ She/Her/Hers ☐ They/Them/Theirs ☐ He/Him/His ☐ Not Listed: _____		
What is your gender identity?		What is your sexual orientation?		
☐ Female ☐ Male ☐ Nonbinary ☐ Genderqueer ☐ Two-spirit ☐ Choose not to answer ☐ Identity not Listed: _____		☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't Know ☐ Asexual ☐ Choose not to answer ☐ Orientation not listed: _____		
What is your race? (check all that apply)				
☐ American Indian or Alaskan Native Tribal Affiliation: _____ ☐ Black or African American ☐ White ☐ Asian Indian ☐ Korean ☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Thai ☐ Filipino ☐ Other Asian ☐ Native Hawaiian ☐ Chamorro ☐ Guamanian ☐ Samoan ☐ Tongan ☐ Other Pacific Islander ☐ Race not listed ☐ Choose not to answer				
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What is your ethnicity?			
☐ Hispanic, Latino or Spanish Origin ☐ Not of Hispanic, Latino, or Spanish Origin ☐ Mexican, Mexican American ☐ Cuban ☐ Puerto Rican ☐ Ethnicity not listed ☐ Choose not to answer			
Veteran Status	☐ Yes – Separated ☐ Yes – Currently Serving ☐ No - Never Served ☐ Choose not to answer		
Medicare?	☐ Yes	☐ No	Number:
Medicaid?	☐ Yes	☐ No	Number:

PARENT OR LEGAL GUARDIAN – Please list all parent or legal guardian information below

We Require Legal Documentation of Legal Guardians

First Name	MI	Last Name	Date of Birth
Social Security Number	Relationship to Patient? (e.g. parent, grandparent, legal guardian, power of attorney)		
Mailing Address (If different from patient)	City	State	ZIP
Phone Number	Employment Status	Authorized Mail Receiver	
		☐ Yes ☐ No	
Language	Email Address (please print clearly)		

ADDITIONAL PARENT OR LEGAL GUARDIAN – Skip this section if there is no additional parent or legal guardian

We Require Legal Documentation of Legal Guardians

First Name	MI	Last Name	Date of Birth
Social Security Number	Relationship to Patient? (e.g. parent, grandparent, legal guardian, power of attorney)		
Mailing Address (If different from patient)	City	State	ZIP
Phone Number	Employment Status	Authorized Mail Receiver	
		☐ Yes ☐ No	
Language	Email Address (please print clearly)		

EMERGENCY CONTACTS – For emergency use only. Listing individuals below does not authorize them to schedule appointments or discuss your protected health information with us. If you would like any of the individuals listed below to assist with scheduling appointments or have access to your protected health information, please speak with our front desk staff.

Full name	Relationship	Phone Number	Same Household
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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HOUSEHOLD INCOME INFORMATION

To maintain federal funding for our discounted services, we are required to collect household and income information from all our patients, including those who choose not to apply for financial support. Even if you do not plan to apply for assistance, please help us continue to offer discounts by answering the questions below. Thank you!

WHAT IS A HOUSEHOLD?

A household includes all individuals who live together and are related by birth, marriage, or adoption. It also includes all individuals who may or may not live together but share a taxed household.

Including yourself, how many people live in your household?

What is your estimated yearly household income?

\$

A separate application is required to apply for the Sliding Fee Scale. Are you interested in applying for the Sliding Fee Scale?

[] **YES-** I have received information on PHC's sliding fee scale. I would like to apply for this discount. I will provide proof of income for every working member of my household.

[] **NO-** I have received information on PHC's sliding fee scale, and I choose not to apply for this discount. I understand that if I am experiencing houselessness or have Medicaid, a slide may be set for my benefit. I understand that after my insurance payments, I will be billed at full fee for balances not covered by my insurance.



Ask staff for more information!