NEW Health

REGISTRATION FORM *(Please fill out completely)*

PATIENT INFORMATION

Today's Date:

LAST NAME:		**FIRST NAME:**		**MI:**		**DOB(M/D/Y):**	
ADDRESS:		**CITY:**		**ST:**		**ZIP CODE:**	
SOCIAL SECURITY #:		**MARITIAL STATUS:**					

SEXUAL ORIENTATION: ☐ Lesbian or gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

GENDER IDENTITY: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to Female ☐ Choose not to disclose ☐ Other:

ASSIGNED SEX AT BIRTH: ☐ Male ☐ Female ☐ Choose not to disclose ☐ Unknown

HOME #:		**MOBILE #:**		**EMAIL:**	

PREFERRED CONTACT METHOD: ☐ Text ☐ Email ☐ Phone **PREFERRED PHARMACY:**

HOW DID YOU HEAR ABOUT US? ☐ Advertising ☐ PCP ☐ Specialist ☐ Word of Mouth ☐ Patient ☐ Hospital ☐ Insurance Company ☐ Other:

DATA SURVEY

In an effort to comply with requirements regarding federal record-keeping and reporting, we ask that you complete the following data survey. Your cooperation is appreciated.

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Russian ☐ Other

INTERPRETER NEEDED: ☐ No ☐ Yes

Is your primary residence considered public housing? ☐ No ☐ Yes

ETHNICITY	RACE	SPECIAL POPULATION	FAMILY SIZE	ANNUAL INCOME RANGE
☐ Hispanic (Latino)	☐ Black (African American)	☐ Migrant Worker	☐ 1	☐ 0 - $13,000
☐ Non-Hispanic (Latino)	☐ White	☐ Seasonal Worker	☐ 2	☐ $13001 - $17000
☐ Decline to provide	☐ Asian	☐ Homeless	☐ 3	☐ $17001 - $22000
	☐ American Indian/Alaska Native		☐ 4	☐ $22001 - $27000
VETERAN	☐ Native Hawaiian		☐ 5	☐ $27001 - $31000
☐ No	☐ Other Pacific Islander		☐ 6	☐ $31001 - $36000
☐ Yes	☐ Multiracial - select all from above		☐ 7	☐ $36001 - $40000
☐ Decline to provide	☐ Decline to provide		☐ 8	☐ $40001 - $45000
			☐ 9+	☐ $45001+

RESPONSIBLE PARTY

SOCIAL SECURITY #:		**RELATIONSHIP TO PATIENT:**					
LAST NAME:		**FIRST NAME:**		**MI:**		**DOB(M/D/Y):**	
ADDRESS:		**CITY:**		**ST:**		**ZIP CODE:**	
HOME #:		**MOBILE #:**		**EMAIL:**			

INSURED INFORMATION

MEDICAL

LAST NAME:		**FIRST NAME:**		**MI:**		**DOB(M/D/Y):**	
EMPLOYER:		**EMPL. PHONE:**		**INSURANCE CO:**			
POLICY #:		**GROUP #:**		**EFFECTIVE DATE:**			
ADDRESS:		**CITY:**		**ST:**		**ZIP CODE:**	
INS. PHONE:		**RELATIONSHIP TO PATIENT:**					

DENTAL

LAST NAME:		**FIRST NAME:**		**MI:**		**DOB(M/D/Y):**	
EMPLOYER:		**EMPL. PHONE:**		**INSURANCE CO:**			
POLICY #:		**GROUP #:**		**EFFECTIVE DATE:**			
ADDRESS:		**CITY:**		**ST:**		**ZIP CODE:**	
INS. PHONE:		**RELATIONSHIP TO PATIENT:**					

EMERGENCY CONTACT

NAME:		**RELATIONSHIP TO PATIENT:**					
ADDRESS:		**CITY:**		**ST:**		**ZIP CODE:**	**PHONE:**

NEW Health

ACKNOWLEDGEMENT AND AUTHORIZATION	
Please check each item below. Sign and date at the bottom of the page.	
	I have read and understand the HIPAA/Privacy Policy for NEW Health.
	I hereby assign my insurance benefits to be paid directly to NEW Health.
	I authorize NEW Health to release medical/dental information required to process my claim.
	I have read and understand the Appointment Policy for NEW Health.
	I authorize NEW Health to obtain/have access to my medication, vaccine, and health history.
	I authorize my provider's office to contact me by mobile phone including text messaging. *We call or send texts/email regarding your appointments, updates, surveys, and newsletters approximately 1-2 per week. You can change your contact preferences at any time either by text, email, online or by contacting the clinic. You are responsible for any text or data charges that may occur.*
	I authorize NEW Health to mail or leave detailed messages regarding appointments and/or lab results with the individual answering my home or mobile number or voicemail system.
	I authorize my provider's office to obtain my photograph for proof of identity.

Please list the names of persons authorized by you to receive your health information, verbally, pick up medication, prescriptions or copies of personal paperwork.			
Name:		**Relationship:**	
Name:		**Relationship:**	
NOTE: *Photo ID and signature are required by person picking up prescriptions or copies of other information.*			

SIGNATURE *I certify that the information provided is correct.*	
PATIENT (or GUARDIAN) SIGNATURE	**DATE**