REGISTRATION FORM (PLEASE FILL OUT COMPLETELY)

Patient Information

LAST NAME: FIRST NAME: MI: DOB (M/D/Y):

ADDRESS:

CITY: ST: ZIP CODE:

MAILING ADDRESS:

SOCIAL SECURITY # Marital Status: Sex Assigned at Birth: Male ☐ Female ☐

Home #________________________ Mobile #________________________ Email____________________________

Preferred Contact Method: Text ☐ Email ☐ Phone ☐ Preferred Pharmacy______________________________

Sexual Orientation: Straight (not lesbian or gay) ☐ 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 ☐

Data Survey- To comply with requirements regarding federal record-keeping & reporting, we ask that you complete the following data survey. YOUR COOPERATION IS APPRECIATED

Primary Language: English ☐ Spanish ☐ Other ☐_____________ Interpreter Needed? Yes ☐ No ☐

Are you a Veteran? Yes ☐ No ☐

Ethnicity	Race	Special Population	Family Size	Annual Income
☐ Hispanic (Latino)	☐ Black (African-American)	☐ Migrant Worker	☐ 1	☐ $0-$15,060
☐ Non-Hispanic (Latino)	☐ White	☐ Seasonal Worker	☐ 2	☐ $15,061-$20,440
☐ Unreported/Refused	☐ Asian	☐ Homeless	☐ 3	☐ $20,441-$25,825
	☐ American Indian/Alaska Native		☐ 4	☐ $25,826-$31,200
	☐ Native Hawaiian	☐ Public Housing	☐ 5	☐ $31,201-$36,580
	☐ Other Pacific Islander		☐ 6	☐ $36,581-$41,960
	☐ Multiracial-select 2 from above		☐ 7	☐ $41,961-$47,340
	☐ Unreported		☐ 8	☐ $47,341-$52,720
			☐ 9+	☐ $52,721+

RESPONSIBLE PARTY

Last Name: First Name: MI: DOB(M/D/Y):

Social Security # Relationship to Patient:

Address: City: ST: Zip Code:

Home # Mobile # Email:

INSURED INFORMATION MEDICAL ☐ DENTAL ☐

Last Name: First Name: MI: DOB(M/D/Y):

Employer: Telephone #

Insurance: Policy # Group # Effective Date:

Relationship to Patient:

EMERGENCY CONTACT

Name: Relationship to Patient: Phone #

How did you hear about us?

Signature: ____ Date: ____________________

****Please check each item below. Sign and date at the bottom****

ACKNOWLEDGEMENT AND AUTHORIZATION:

- ☐ 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/emails regarding your appointments, updated, 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 appointment and/or lab results with the individual answering my home 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 required by person picking up prescriptions or copies of other information

I certify that the information provided is correct.

Signature: ____ Date____________________