NORTHWEST COLORADO HEALTH

Patient Registration

Patient Information

Legal Name* Last	First	Middle Initial	**Name used:**
Date of Birth *Month Day Year* / /		**Social Security #**	
Home Phone ( )		**Cell Phone** ( )	
Mailing Address	City	State	Zip
Physical Address (if different from mailing)	City	State	Zip
Emergency Contact's Name	Phone Number	Relationship to Patient	

Responsible Party Information (For all patients under age 18)

Name	Phone Number	Relationship to Patient	
Mailing Address	City	State	Zip

Demographic Information

1.) Sex at birth

- ☐ Female
- ☐ Male

2.) Current Marital Status

- ❑ Married
- ❑ Partnered
- ❑ Single
- ❑ Divorced
- ❑ Separated
- ❑ Widowed

3.) Gross annual (before taxes) household income? (include spouse)

$_____ ☐ No income

3a.) How many people (including you) does your income support? (if you are pregnant count unborn baby(ies)

_____

4.) Race (check all that apply)

- ❑ African American / Black
- ❑ Asian
- ❑ Caucasian / White
- ❑ Native American / Alaskan Native / Inuit
- ❑ Pacific Islander
- ❑ Other
- ❑ Refuse to Report

5.) Ethnicity

- ❑ Hispanic/Latino/Latina
- ❑ Not Hispanic/ Latino/Latina
- ❑ Refuse to Report

6.) Migrant?

- ☐ Yes
- ☐ No

7.) Veteran?

- ☐ Yes
- ☐ No

8.) United States Citizen or Legal Immigrant?

- ☐ Yes
- ☐ No

9.) Public Housing Resident?

- ☐ Yes
- ☐ No

10.) Pharmacy of Choice:

_____

10.) Gender Identity

- ☐ Female
- ☐ Male
- ☐ Transgender F→M
- ☐ Transgender M→F
- ☐ Other
- ☐ Choose not to disclose

11.) Sexual Orientation?

- ☐ Straight
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't know
- ☐ Choose not to disclose

12.) Referral Source

- ❑ Self
- ❑ Friend or Family Member
- ❑ Health Provider
- ❑ Emergency Room
- ❑ Internet/newspaper/radio
- ❑ Other _____

I hereby certify that all of the information given, including income, is correct.

_____ ____/____/____ _____

Signature Month Day Year Relationship (if not patient signing)