Patient Name: _____ Date of Birth: _____

PATIENT REGISTRATION FORM

NORTHWEST COLORADO HEALTH

Patient Information

Legal Name* Last	First	Middle Initial	**Preferred Name:**	
Previous Name Last	First	Middle Initial		
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	Date of Birth / /
Mailing Address	City	State	Zip

Demographic Information

1) Sex at birth ❑ Female ❑ Male	**2) Current Marital Status** ❑ Married ❑ Partnered ❑ Single ❑ Divorced ❑ Legally Separated ❑ Widowed	**3)Student Status** ❑ Full Time Student ❑ Part-time student ❑ Not a student

Please turn over

Patient Name: _____ Date of Birth: _____

4) Employment Status ❑ Full-time ❑ Part-time ❑ Not-employed ❑ Self-employed ❑ Retired ❑ Active Military Duty ❑ Reserved for National Assignment **Employer:**	**5) Pharmacy of Choice:** Name City/State	**6) Gross annual (before taxes) household income? (include spouse)** **$**_____ ☐ No income **6a) How many people (including yourself) does your income support? (if you are pregnant count unborn baby(ies)** _____	
7) Race (check all that apply) ❑ African American / Black ❑ Asian ❑ Caucasian / White ❑ Native American / Alaskan Native / Inuit ❑ Pacific Islander ❑ Other, Please Specify: _____	**8) Ethnicity** ❑ Hispanic/Latino/Latina ❑ Not Hispanic/Latino	**9) Migrant?** ❑ Yes ❑ No **10) US Veteran?** ❑ Yes ❑ No	**11) United States Citizen or Legal Immigrant?** ❑ Yes ❑ No **12) Public Housing Resident?** ❑ Yes ❑ No
13) Homeless ❑ Not Homeless (has permanent established residence) ❑ Primary Residence is Supervised Private or Public Facility ❑ Transitional Housing ❑ Lives on Street ❑ Lives in Car ❑ Lives at a Shelter ❑ Stays with Family/Friends ❑ Other, Please Specify: _____	**14) Gender Identity** ❑ Female ❑ Male ❑ Transgender F→M ❑ Transgender M→F ❑ Other ❑ Choose not to disclose	**15) Sexual Orientation?** ❑ Straight ❑ Lesbian or Gay ❑ Bisexual ❑ Something Else ❑ Don't know ❑ Choose not to disclose	**16) 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 to patient if not self

Staff Initials: _____ Revision: December 2017