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**<br>❑ Female<br>❑ Male | **2) Current Marital Status**<br>❑ Married<br>❑ Partnered<br>❑ Single<br>❑ Divorced<br>❑ Legally Separated<br>❑ Widowed | **3)Student Status**<br>❑ Full Time Student<br>❑ Part-time student<br>❑ Not a student |

**Please turn over**

Patient Name: _____ Date of Birth: _____

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