Patient Name: _____ Date of Birth: _____

NORTHWEST COLORADO HEALTH

PATIENT REGISTRATION FORM

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	

Do you have insurance: Yes ◯ No ◯ Name of your insurance company: _____
Please present insurance card to front desk.

Insurance Payments: We participate in assignment of payment with **specific** insurances (posted at the front desk) in our area. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for any unpaid balances left on your account regardless of the amount of insurance coverage.

Patient Copays: Patient copays is expected at time of service for all appointments

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

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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

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