CrescentCare

REGISTRATION FORM

(Please Print)

Today's Date:	**Location:** (*Office Use*) ❑CCEF ❑CCHWC ❑PREVENTION ❑HOUMA ❑Other:_____

PATIENT INFORMATION

Last Name:	**First Name:**	**MI:**

If you have medical insurance, what is the name listed on your card?	**Preferred Name:**

Legal Sex: (*Please Check One*) ❑Female ❑Male

While CrescentCare recognizes a diversity of gender identities, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents related to insurance, billing and occasional correspondence. If you are uninsured, then "Legal Sex" is considered the sex listed on your state ID.

Mailing/Billing Address including City, State, Zip	**Physical Address including City, State, Zip** (if different than mailing/billing address)

Home Phone #:	**Cell Phone #:**	**Appointment Reminder Preference:**
( )	( )	❑ Call ❑ Text ❑ Do Not Contact

Email Address:

Birth Date:	**Social Security #:**	**Marital Status:**
/ /		❑ Single ❑ Divorced ❑ Partnered ❑ Married ❑ Separated ❑ Widowed

Race: Check all that apply

❑ Black or African-American
❑ White
❑ American Indian or Alaska Native
❑ Asian
❑ Pacific Islander
❑ Other:_____

Ethnicity:

❑ No, not Hispanic or Latino/a.
❑ Yes, Hispanic/Latino

Housing Status:

❑ Stable/Permanent
❑ Other:_____
❑ Transitional
❑ Doubling up
❑ Homeless
❑ Street
❑ Unknown

What *best* describes your employment status?

❑ Employed full-time
❑ Employed part-time
❑ Self-Employed
❑ Unemployed
❑ Homemaker/Caretaker
❑ Retired

Are you a student?

❑ Not a student
❑ Full-time student
❑ Part-time student

If you have a primary care provider you see who is not with CrescentCare, list them here:

CC Employee_____

Today's Date:	Date of Birth:	Patient's Name:

Do you identify as:	Preferred Gender Pronouns:	Sex Assigned at Birth:	Do You Identify As Transgender?	Do you consider yourself to be:
❑ Male ❑ Female ❑ Genderqueer, nonbinary, neither exclusively male nor female	❑ He/him ❑ She/her ❑ They/them	❑ Male ❑ Female	❑ Yes ❑ No	❑Straight or heterosexual ❑Lesbian, gay,or homosexual ❑Bisexual ❑Something else ❑Don't know ❑Choose not to disclose

Veteran Status:	Agricultural/Migrant Status:	Do you need a translator?
❑ Veteran ❑ Non-Veteran	❑ Migrant ❑ Does Not Apply ❑ Seasonal	❑ Yes/Sí/Oui/Vâng ❑ No

What language are you most comfortable speaking?	What language are you most comfortable reading?	What language are you most comfortable writing?
❑ English/Inglés ❑ Spanish/Español ❑ Other:_____	❑ English/Inglés ❑ Spanish/Español ❑ Other:_____	❑ English/Inglés ❑ Spanish/Español ❑ Other:_____

Highest level of school:

❑ Elementary	❑ Some college or technical school	❑ Any post graduate studies
❑ Some high school	❑ Associate's degree	❑ Master's degree
❑ High school diploma or GED	❑ Bachelor's degree	❑ Doctorate's degree

How do you *usually* get to medical appointments?

❑ Drive Myself	❑ Take Bus/Street Car	❑ Bicycle	❑ Medicaid Transportation
❑ Ride with family/friends	❑ Walk	❑ Taxi or Ride Sharing App	

EMERGENCY CONTACT INFORMATION

First Name	Last Name	Relationship to patient:

Phone #1	Phone #2

How many family members, including yourself, do you currently live with?	Household Income:	Preferred Pharmacy (Name and Address)

The above information is true to the best of my knowledge.

Patient / Guardian Name (Print):

Patient / Guardian (Signature): | *Date:*

Relationship to Patient:

CC Employee_____