CrescentCare
A Partnership for Life

CRESCENTCARE PATIENT REGISTRATION FORM

As a community health center, we are required to collect demographic information about our patients. We understand that it is personal information, and we appreciate that you support our data collection so that we may better serve our community. This information will become a part of your confidential medical record.

Last Name + Suffix: _____ First Name:_____MI: ___

Chosen/Preferred Name (if different): _____ Email: _____

Mailing/Physical Address: _____

City: _____ State: _____ Zip:_____ Phone Number: _____

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____

Patient's pronouns ☐ She/Her ☐ He/Him ☐ They / Them

Patient's Sex Assigned at Birth ☐ Female ☐ Male

Patient's Sexual Orientation: ☐ Straight or Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian
☐ Do Not Know ☐ Choose not to disclose ☐ Other _____

EMERGENCY CONTACT: Full Name: _____

Relationship to Patient: _____

Emergency Contact Telephone Number: _____

INSURANCE INFORMATION OR RESPONSIBLE PARTY

Plan Holder: _____DOB___-___-____ Relationship to Patient: _____

Health Plan Name _____ Address: _____

Member Name_____ City/State Zip: _____

Member ID: _____ Phone Number: _____

Primary Care Physician/ Location: _____

Patient's Gender Identity: ☐ Female ☐ Male ☐ Transman ☐ Transwoman ☐ Choose not to disclose
☐ Non-Binary / Genderqueer ☐ Other _____

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Ethnic Group:	Race:	
☐ Non-Hispanic	☐ White	☐ Asian
☐ Hispanic or Latino/a	☐ Black/African American	☐ Asian Indian
☐ Mexican	☐ Native Hawaiian	☐ Chinese
☐ Mexican American	☐ Guamanian or Chamorro	☐ Filipino
☐ Chicano/a	☐ Samoan	☐ Japanese
☐ Puerto Rican	☐ Other Pacific Islander	☐ Korean
☐ Cuban	☐ American Indian/Alaskan Native	☐ Vietnamese
☐ Choose not to disclose.	☐ Choose not to disclose	☐ Other Asian

United States Veteran / Military Status: ☐ Active Duty ☐ Inactive Duty ☐ Reservist ☐ Veteran

Agricultural/Migrant Status: ☐ Migrant ☐ Seasonal ☐ Does Not Apply

Has the patient experienced homelessness in the last 12 months? ☐ Yes ☐ No

If yes, has the patient stayed in any of the following: ☐ Homeless Shelter ☐ Doubling Up

☐ On Street ☐ Other: _____

Advanced Directive: Do you have an advanced directive? ☐ Yes ☐ No

Preferred Language: _____ Interpreter needed? ☐ Yes ☐ No

Visually or hearing impaired? ☐ Yes ☐ No

IF PATIENT IS AGE 17 OR UNDER; INFORMATION ABOUT PARENT(s) OR LEGAL GUARDIAN(s):

#1 Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Phone Number: _____

Address (if different from patient): _____

#2 Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Phone Number: _____

Address (if different from patient): _____

ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

I authorize payment for all medical benefits to CrescentCare for professional service rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collection and reasonable attorney fees.

Patient / Guardian Signature: _____ Date: _____