CRESCENTCARE PATIENT REGISTRATION FORM

CrescentCare
A Partnership for Life

We 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.

Legal Last Name + Suffix: _____ Legal First Name: _____ MI: ____

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

Mailing/Physical Address: _____

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

Date of Birth: ___/___/___ Social Security Number: _____ – _____ – _____

Preferred Language: _____ Interpreter needed? ☐ Yes ☐ No

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

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 _____

Patient's Gender Identity: ☐ Cis Woman/Female ☐ Cis Man/Male ☐ Non-Binary/Genderqueer ☐ Transgender Man/Transgender Male/Transmasculine ☐ Transgender Woman/Transgender Female/Transfeminine ☐ Choose not to disclose ☐ Other _____

U.S. Veteran/Military Status: ☐ Active Duty ☐ Inactive Duty ☐ Reservist ☐ Veteran ☐ Does not apply

Agricultural/Migrant Status: ☐ Migrant ☐ Seasonal ☐ Does not apply

Housing Status: ☐ Stable/Permanent ☐ Transitional ☐ Homeless ☐ Doubling Up ☐ Street ☐ Other

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Advanced Directive: **Do you have an advanced directive?** (A form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are unable to respond): ☐ 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): _____

INSURANCE INFORMATION OR RESPONSIBLE PARTY

Plan Holder: _____ DOB: ___/___/___ Relationship to Patient: _____

Health Plan Name: _____ Address: _____

Name on Insurance Card: _____ City/State/Zip: _____

Sex on file with insurance plan: _____

Member ID: _____ Phone Number: _____

Primary Care Physician: _____ Preferred Pharmacy/Location: _____

EMERGENCY CONTACT

Full Name: _____ Relationship to Patient: _____

Emergency Contact Telephone Number: _____

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: _____