COMMUNITY CARE PHYSICIANS

New Patient Registration

Name on Legal Documents* Last First Middle Initial	Name you would like us to use
Sex on Legal Documents* FEMALE MALE *While we recognize a number of genders / sexes, 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 pertaining to insurance, billing and correspondence. If your name and pronouns are different from these, please let us know*	**What are your pronouns?** (e.g., he/him, she/her, they/them)
Date of Birth Month/Day/Year / /	

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone#	Cell Phone#	Work Phone#	Best Phone # to use: Cell Home Work

Local Address City State ZIP

Billing Address (if different from above) City State ZIP

Email Address

Emergency Contact's Name **Phone#** **Relationship to you**

Parent/Guardian Name (if under 18yo) **Phone#** **Relationship to you**

We will send certain correspondence, such as bills, to your mailing address.
How would you prefer to receive other types of written correspondence? (circle one) Secure Web-based Portal Letter Other

This information is for demographic purposes and will only inform your care.

1. Marital Status	2.Employment Status	3. Racial Group(s)	4. Ethnicity
☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Other_____________	☐ Employed full time / part time ☐Student full time / part time ☐ Disabled ☐ Retired ☐ Unemployed ☐ Decline to say ☐ Other ________________	☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Native American/Alaskan ☐ Pacific Islander ☐ Other ____________ ☐ Decline to say	☐ Hispanic/Latino/Latina ☐ Not Hispanic/Latino/Latina ☐ Decline to say
5. Preferred language	**6. Any Additional Needs**	**7. Veteran Status**	**8. Referral Source**
☐ English ☐Español ☐Français ☐Arabic ☐ Burmese ☐ Chinese ☐Dari/Farsi ☐Other ______________	☐Mobility Impaired ☐Manual wheelchair ☐Power chair/scooter ☐Rolling walker ☐Other ____________ ☐Hearing Impaired ☐Visually Impaired ☐Other _______________	☐ Veteran ☐ Not a veteran	☐ Self ☐ Friend or Family Member ☐ Health Provider ☐ Emergency Room ☐ Ad/Internet/Media ☐ Outreach Worker/School ☐ Other _____________

9. What is your current gender identity? (Check one)
☐ Male
☐ Female
☐ Transgender Male/Trans Man/ Female-to-Male (FTM)
☐ Transgender Female/Trans Woman/ Male-to-Female (MTF)
☐ Choose not to disclose
☐ Genderqueer, neither exclusively male nor female
☐ Additional gender category, please specify: ______________________

10. What sex were you assigned at birth? Female Male

INSURANCE INFORMATION

Primary Insurance
Name of Policy Holder/Guarantor: ________________________ DOB: ________ Relationship to Patient: _______________________
Insurance Company: ____
Insured's Policy/ ID #: _____________________ Group #: __________________
Insurance Co. Address: ________________________ Phone #: ______________

Secondary Insurance
Name of Policy Holder/Guarantor: ________________________ DOB: ________ Relationship to Patient: _______________________
Insurance Company: ____
Insured's Policy/ ID #: _____________________ Group #: __________________
Insurance Co. Address: ________________________ Phone #: ______________