St.Jude Neighborhood Health with Providence

Patient Registration

Our Mission: Through our faith-based centers, we improve the health and well-being of low-income persons in the communities we serve.

Thank you for choosing us as your healthcare provider. For efficient registration, please complete ALL questions on this form. If it does not apply mark N/A.

Last Name: ________________________________ **First Name:** _________________________________

Middle Name: ______________________________ **Other Names/Alias:** ___________________________

Social Security #: - - ◻ N/A	**Date of Birth:**

Street Address: **City:** **State:** **Zip:**

Mailing Address: **City:** **State:** **Zip:**
(If different than above)

Phone Number(s): ***(Please mark preferred contact number)***	**Email Address:**
☐ **Home:** ____________________________________	**Preferred Language:**
☐ **Cell:** _____________________________________	◻ English ◻ Spanish ◻ Other: ____________________
☐ **Work:** ____________________________________	**Interpreter Needed:** ◻ No ◻ Yes

Sex assigned at birth: ◻ Female ◻ Male

Gender Identity: ◻ Female ◻ Male ◻ Transgender Female (male to female) ◻ Transgender Male (female to male) ◻ Elijo no divulgar ◻ Choose not to disclose ◻ Other:

Sexual Orientation: ◻ Straight/Heterosexual (attracted exclusively to people of the other sex) ◻ Bi-sexual ◻ Lesbian/Gay ◻ Choose not to disclose ◻ Don't know ◻ Unknown ◻ Other:

Marital Status: ◻ Single ◻ Married ◻ Widow/er ◻ Separated ◻ Divorced ◻ Domestic Partner

Ethnicity (select one): ◻ Mexican ◻ Cuban ◻ Puerto Rican ◻ Another Hispanic/Latino ◻ Non-Hispanic/ Non- Latino ◻ Other:

Race (choose all that apply):

☐ American Indian/Alaska Native	☐ Vietnamese
☐ Black/African	☐ Other Asian
☐ American White	☐ Native Hawaiian
☐ Asian	☐ Other Pacific Islander
☐ Asian Indian	☐ Guamanian or Chamorro
☐ Chinese	☐ Samoan
☐ Filipino	☐ More than one race
☐ Japanese	☐ Choose not to disclose
☐ Korean	☐ Other: _______

Deaf/Hard of Hearing: ◻ No ◻ Yes	**Hearing/Visual Needs:** ◻ No ◻ Yes
Blind/Low Vision: ◻ No ◻ Yes	*(please indicate below)* ◻ Sign Language ◻ Tactile/Sign Interpreter
Speech Impaired: ◻ No ◻ Yes	◻ Other: _______________
Religion:	**Primary Care Physician PCP:**
Do you have Health Insurance: ◻ No ◻ Yes	**Insurance Carrier Name and ID #:**

Emergency Contact

Name:	Phone #:	Relationship to Patient:
Street Address: □ *Same as patient*		
City:	**State:**	**Zip:**

Patient Employment Status:

□ Full-time □ Part-time □ Student full-time □ Student part-time □ Disabled □ Active Military □ Retired □ Self-employed □ **Not Employed — move to the next section of the form**			
Employer/Company:		**Phone:**	
Address:		**City:**	
State:	**Zip:**	**County:**	
Occupation:			

Grant Data Information

St. Jude Neighborhood Health Centers, receives grants that support our work. The grant(s) **require** us to collect the following information, therefore are **required** to be answered.

How many people in your family/household: *Family size* ____________	Monthly Salary *$* ____________	Any other Monthly Wages: *$* ____________
HOMELESS As of last night, are you currently homeless? □ Yes □ No *(If you stayed in a shelter, transitional housing, on a friend's sofa, or on the street because you don't have a home, you should answer 'yes'. If NOT HOMELESS, move to the next question)*		
Have you served in the United States military, armed forces, or uniformed services? □ Yes □ No		
Are you or anyone in your family an agriculture worker? **Please note: Individuals working in landscaping or at a dairy are not considered farmworkers* □ Yes □ No		
Do you have an Advance Directive? □ Yes □ No An Advanced Directive is a document describing your wishes regarding medical treatment, often including a living will, that is used if/when you cannot communicate your wishes to a doctor because of an injury or illness.		

Sign and date this form and return it to the front desk. Thank you.
The above information is true to the best of my knowledge. I request and authorize St. Jude Neighborhood Health Centers to provide me with health care services. I understand that St. Jude Neighborhood Health Centers may use and disclose my information as described in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices. I have reviewed and agree to comply with the St. Jude Neighborhood Health Center patient contract. I acknowledge St. Jude Neighborhood Health Centers receives HHS funding and has Federal Public Health Service deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and for its covered individuals. I understand that I will never be denied care due to an inability to pay and that I can apply for discounted fees based on my income.
I understand and agree to notify St. Jude Neighborhood Health Centers if any of the information on this form should change while I am under their care. I understand that I may qualify for reduced fees based on my household income.

________________________________ ________________________________

Signature **Date**

OFFICE USE ONLY:
Clinic Rep. Initials ________ Date Reviewed ________

Form approval: