PATIENT REGISTRATION FORM

Today's Date:___________ First Name:___________________________ Last Name:___________________________ Middle:______

Date of Birth: ____________Sex at Birth: ☐Male ☐Female Social Security:______________________________________

Preferred Name:____ Pronouns:____

Address:____Apt/Unit:_________________

City:____ State:__________________ Zip:_____________________

Home Phone:________________________ Cell Phone:______________________ Email:_____________________________________

How Did You Hear About Us?:____

Sexual Orientation:

☐Lesbian, Gay, or Homosexual

☐Straight or Heterosexual Gender Identity:

☐Bisexual

☐Prefer Not to Disclose

☐Sexual Orientation Identity:______________________________________

Gender Identity:

☐Male

☐Female

☐Non-Binary

☐Androgynous

☐Female-to-Male (FTM) / Transgender Man / Trans Man

☐Male-to-Female (MTF) / Transgender Female / Trans Woman

☐Gender queer, neither exclusively male nor female

☐Prefer not to Disclose

☐Gender Identity:____

Marital Status: ☐Married ☐Divorced ☐Partner ☐Single ☐Widowed ☐Legally Separated

Preferred Language (Idiomia preferida): ________________________Would you like a Translator?(Gustaria interprete):__________

Race: ☐Asian ☐Black or African American ☐Haitian ☐Pacific Islander ☐White ☐Other Race:

Ethnicity: ☐Cuban ☐Hispanic or Latino ☐Latin American ☐Mexican ☐Not Hispanic or Latino ☐Puerto Rican

☐Prefer not to Disclose ☐Other Ethnicity:

Insurance Information:

Do you have health insurance? ☐Yes ☐No **Do you have dental insurance?** ☐Yes ☐No

If Yes, please bring your insurance card(s) to your first appointment.:
If No, there may be options available – please speak to Reza Health staff to explore available options.

Health Insurance:__________________ 2nd Insurance:_____________________ Dental Insurance:___________________
Member ID:________________________ 2nd Member ID:____________________ Dental Member ID:_________________

Primary Care Doctor Name:____ Primary Care Phone:_______________
Emergency Contact Information
Name of local friend or relative:____
Relationship to patient:______________________ Cell phone:________________________ Home phone:______________________
Name of local friend or relative:____
Relationship to patient:______________________ Cell phone:________________________ Home phone:______________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Reza Health. I understand that I am financially responsible for any balance. I also authorize Reza Health or my insurance company to release any information required to process my claims.

Patient/Guardian Signature:____Date:____________________________