NEW HORIZON FAMILY HEALTH SERVICES, INC
PATIENT REGISTRATION FORM

PATIENT CONTACT INFORMATION				
First Name	Middle Name	Last Name	Preferred Name	Former Last Name

Date of Birth / /	Social Security Number	Email Address	Primary Phone for Contact ☐ Home ☐ Cell ☐ Work

Home Phone:	Information may be left on voice mails at my listed phone number. ☐ Yes ☐ No
Cell Phone:	Texts may be sent to my cell phone number. ☐ Yes ☐ No
Work Phone:	I would like to receive automated calls, texts, and/ or emails. ☐ Yes ☐ No

Mailing Address	Apt. #	City	State	Zip Code	County

Home Address (if different from mailing)	Apt. #	City	State	Zip Code	County

Primary Emergency Contact Name	Relationship	Phone

ADDITIONAL INFORMATION			
Number of people living in the home:		Estimated Annual Household Income:	
Sex at Birth ☐ Male ☐ Female	Gender Identity (check one) ☐ Male ☐ Female ☐ Gender queer ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose not to disclose	Sexual Orientation (check one) ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Straight or heterosexual ☐ Something else ☐ Don't know ☐ Choose not to disclose	Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner
Primary Language: (language spoken at home)			

Employment Status (choose one)	Ethnicity (check one)	Race (check all that apply)
☐ Employed ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Student ☐ Choose not to disclose	☐ Non-Hispanic/Non-Latino ☐ Hispanic/ Latino ☐ Cuban ☐ Mexican/ Mexican American ☐ Puerto Rican ☐ Choose not to disclose	☐ Asian ☐ Asian Indian ☐ Chinese ☐ Japanese ☐ Korean ☐ Vietnamese ☐ American Indian/Alaskan Native ☐ Samoan ☐ Pacific Islander ☐ Guamanian/ Chamorro ☐ Filipino ☐ Black/ African American ☐ White ☐ Choose not to disclose ☐ Other _____

Housing Status (choose one)	Are you: (check all that apply)
☐ Own or Rent home ☐ Homeless Shelter ☐ Transitional ☐ Doubling up (staying with friend or family) ☐ Street ☐ Public Housing	☐ Disabled ☐ Veteran ☐ Agricultural worker and/or Migrant ☐ Homebound ☐ School based health center ☐ N/A

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Guarantor (Responsible Party) Information					
☐ Check here if same as patient		**Complete the information below if the Guarantor is different from patient**			
First Name	Middle Name	Last Name	Date of Birth / /	Relationship to Patient	
Address	Apt. #	City	State	Zip Code	Phone

Insurance Information				
Insurance Company	Name of Insured	Insured's Date of Birth	Insured's Social Security Number	Relationship to Patient

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices for New Horizon Family Health Services, Inc. and that I have been given the opportunity to ask questions about the notice.

Patient Signature (or responsible party): _____ **Date:** _____
Relationship to patient: _____

Consent for Treatment/ Authorization to Bill

I consent to necessary treatment by New Horizon Family Health Services, Inc. and authorize them to bill my insurance for any services received. I acknowledge my responsibility to pay for any care not covered by insurance according to the fees and policies established.

Patient Signature (or responsible party): _____ **Date:** _____
Relationship to patient: _____