



**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 <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		
Home Phone:	Information may be left on voice mails at my listed phone number. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Cell Phone:	Texts may be sent to my cell phone number. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Work Phone:	I would like to receive automated calls, texts, and/ or emails. <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Housing Status (choose one) <input type="checkbox"/> Own or Rent home <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling up (staying with friend or family) <input type="checkbox"/> Street <input type="checkbox"/> Public Housing	Are you: (check all that apply) <input type="checkbox"/> Disabled <input type="checkbox"/> Veteran <input type="checkbox"/> Agricultural worker and/or Migrant <input type="checkbox"/> Homebound <input type="checkbox"/> School based health center <input type="checkbox"/> N/A	Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner
Primary Language: (language spoken at home)			
Employment Status (choose one) <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Choose not to disclose	Ethnicity (check one) <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican/ Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Choose not to disclose	Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Samoan <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Guamanian/ Chamorro <input type="checkbox"/> Filipino <input type="checkbox"/> Black/ African American <input type="checkbox"/> White <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other _____	



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Guarantor (Responsible Party) Information					
<input type="checkbox"/> 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 hereby consent to receive necessary treatment from New Horizon Family Health Services, Inc. (NHFHS) and authorize the organization to submit claims to my insurance provider for services rendered. I further authorize NHFHS to identify and bill any applicable third-party coverage on my behalf. I understand and accept responsibility for all costs of care not covered by insurance, in accordance with NHFHS's established fees and policies. Additionally, I specifically authorize NHFHS to disclose my medical information for the purposes of treatment, referral, and payment.

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