The Christ Hospital Health Network

THE CHRIST HOSPITAL PHYSICIAN DIVISION

PATIENT REGISTRATION INFORMATION R-7230 REV. 6/20 PAGE 1 OF 2

Today's Date: _____

Patient Information: (please print)

Legal Name: _____
Last First Middle Initial

Social Security Number: _____ Preferred Name: _____ Date of Birth: _____

Legal Sex*: ☐ Male ☐ Female ☐ Unknown
*Legal Sex is what is listed on your IDs such as Driver's License, Passport, Green Card, Insurance card, etc.

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
☐ Self Reported: _____ ☐ Choose not to disclose

Sex assigned at birth: ☐ Male ☐ Female ☐ Unknown ☐ Uncertain ☐ Not Recorded on Birth Certificate ☐ Choose not to disclose

Sexual Orientation: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't Know ☐ Something Else ☐ Choose not to disclose

Address: _____
Number Street City State Zip

Home #: (___) _____ Work #: (___) _____ Cell #: (___) _____

Email Address: _____ Marital Status: S___ M___ D___ W___ Separated___ Partner___

Religion: _____ Family/Primary DR.: _____

Race: White___ African American___ American Indian___ Asian___ Native Alaskan___ Native Hawaiian___ Refused___ Other_____

Ethnicity: Non-Hispanic_____ Hispanic_____

Primary Language Spoken (patient): _____ Primary Language Spoken (caregiver): _____

Need Interpreter: Y___ N___

Military Service: Not a Veteran ___ Air Force ___ Army ___ Coast Guard ___ Marines ___ Multiple Branches ___ Navy ___

Employment Information: Retired: Y N Retirement Date: _____

Patient/Guardian Employer: _____ Patient's Occupation: _____

Employer Address: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Other: _____

Please Print:

Parent or Legal Guardian's Legal Name: _____
(If applicable) Last First Middle Initial

Date of Birth: _____ SSN#: _____
(If only different from patient) (If only different from patient)

Insurance Information:

Insurance Name: _____ Insurance ID#: _____

Subscriber Info: Name: _____ Patient Relationship to Subscriber: Self___ Spouse___ Child___ Other_____

DOB: _____ SSN#: _____

Employer: _____ Employer Address: _____ Group ID#: _____
(If different from above)

Insurance Name: _____ Insurance ID#: _____

Subscriber Info: Name: _____ Patient Relationship to Subscriber: Self___ Spouse___ Child___ Other_____

DOB: _____ SSN#: _____

Employer: _____ Employer Address: _____ Group ID#: _____
(If different from above)

Does the Patient have a Living Will or Health Care Power of Attorney (POA)? Y___ N___

Have we received a copy? Y___ N___

Healthcare POA Name: _____ Phone #: (_____)_____

R 7 2 3 0

Today's Date: _____

Patient's Legal Name: _____ _____
Last First Middle Initial Date of Birth

Contacts: In the event you are incapacitated, there is an emergency, or if we are unable to reach you, are we permitted to discuss or release your health information* to the following identified individual(s)?:

☐ Yes (Complete information below) ☐ No (Skip to the next question)

Name: _____ Name: _____

Relationship to Pt: _____ Relationship to Pt: _____

Home #: (_____) _____ Home #: (_____) _____

Work #: (_____) _____ Work #: (_____) _____

Cell #: (_____) _____ Cell #: (_____) _____

*health information includes, but is not limited to: test results, prescription refills, billing questions and if needed, cases of emergency.

May we leave messages/test results on your answer machine? Y N

May we call you at your place of employment? Y N

If printed prescriptions or sample medications are needed, the following may pick up prescriptions and/or sample medications:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHP. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

❑ I received a copy of the Notice of Privacy Practices.

❑ I have previously received a copy of the Notice of Privacy Practices.

❑ I do not want a copy of the Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT (if 18 years or older) OR LEGAL GUARDIAN IF APPLICABLE Date/Time