The Christ Hospital Health Network

THE CHRIST HOSPITAL PHYSICIANS

PATIENT REGISTRATION INFORMATION R-7230-L REV. 6/20 PAGE 1 OF 3

Patient Information: (please print) Today's Date: _____

Legal Name: _____
Last First Middle Initial

Social Security Number: _____ Date of Birth: _____

Preferred Name: _____

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 ___

R7230

Today's Date: _____

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: _____
(If different from above)

Group ID#: _____

Insurance Name: _____

Insurance ID#: _____

Subscriber Info: Name: _____

Patient Relationship to Subscriber: Self____ Spouse ____ Child ____ Other____

DOB: _____ SSN#: _____

Employer: _____ Employer Address: _____
(If different from above)

Group ID#: _____

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 #: (_____)_____

Today's Date: _____

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

Contacts: 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 have 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 PATIENT IF APPLICABLE

Date/Time