DAMIAN FAMILY CARE CENTERS, INC.

PATIENT PRE-REGISTRATION FORM

(Please Print) **Patient/Relative/Guardian: Complete all applicable information and sign the form**

SECTION I: PATIENT INFORMATION

Patient Name

Last:_____

First: _____

Middle:_____

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Marital Status (circle one): Single / Mar / Div / Sep / Wid

Street Address: _____ P.O. Box (if Applicable): _____

City/State/Zip Code: _____

Social Security No: _____ **Birth Date:** _____ **Age:** _____

Home Phone: ( ) _____-_____

Occupation: _____

Email Address: _____

Employer: _____

Employer Phone No: ( ) _____-_____

Are you a Veteran? ☐ Yes ☐ No

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to Specify

Race (If multiracial, select all that apply):
☐ White (Caucasian)
☐ Native American or Alaskan Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Middle Eastern or North African
☐ Asian
☐ Mixed or Multiracial
☐ Prefer not to answer
☐ Other (please specify):_____

_____

Primary Language
☐ English
☐ Spanish
☐ Tagalog
☐ Chinese
☐ Arabic
☐ French
☐ Russian
☐ Creole
☐ Bengali
☐ Other *(Please tell us what language you speak):*

_____

Sex at Birth:
☐ Male
☐ Female

Sexual Orientation:
☐ Straight (Not Lesbian or gay)
☐ Lesbian / Gay
☐ Bisexual
☐ Something Else
☐ Don't Know
☐ Choose Not to Disclose

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male *(F→M)*
☐ Transgender Female *(M→F)*
☐ Other
☐ Choose Not to Disclose

Housing

☐ Homeless Shelter
☐ Transitional: Temporary Housing Awaiting Permanent Mailing Address
☐ Doubling: Staying with Relative/Friend of Other/Move from Place to Place
☐ Street: Outdoors/Car/Unsafe Place
☐ Have Adequate Housing with Permanent Mailing Address
☐ Other: _____

IN CASE OF EMERGENCY

Name of local friend or relative *(not living at same address):* _____

Relationship to Patient: _____

Home Phone: ( ) _____-_____ **Work Phone:** ( ) _____-_____

Patient/Guardian Signature: _____ **Date:** _____

Advance Directive (Please check if you have an advanced directive)

☐ Yes ☐ No

HOW DID YOU HEAR ABOUT US? (check one)

☐ Doctor / Hospital / Healthcare Provider
☐ Insurance Plan
☐ Family or Friend
☐ School or Child Services
☐ Community Organization / Program
☐ Shelter / Housing Program
☐ Event (Health Fair, Outreach)
☐ Returning Patient
☐ Staff / Employee Referral
☐ Other: _____

If applicable, please provide name (person, organization, or places): _____

_____

PHARMACY INFORMATION

Preferred Pharmacy Name:_____

Address: _____

Phone Number: ( ) _____-_____ **Fax Number:** ( ) _____-_____

SECTION II: INSURANCE INFORMATION

Person Responsible for Bill: _____ **Birth Date:** _____/_____/_____

Address *(if different):* _____

Home Phone: ( ) _____-_____

Occupation: _____

Employer Name: _____

Employer Address: _____

Employer Phone: ( ) _____-_____

Is this patient covered by insurance? ☐ Yes ☐ No

Primary Insurance:

☐ Private
☐ Medicare
☐ Medicaid
☐ Other *(indicate):* _____

Subscriber Name: _____

Subscriber S.S. no: _____

Birth Date: _____/_____/_____ **Group No:** _____

Policy No: _____ **Co-payment:** $_____

Patient Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other

Would you like to participate in our Sliding Fee Program?

☐ Yes ☐ No

Patient/Guardian Signature: _____ *Date:* _____

SECTION III: TO BE COMPLETED BY DFCC STAFF ONLY

Clinic Location (Check one):

☐ DFCC	☐ Wards Island	☐ 121 ST
☐ 53rd	☐ 3RD Ave.	☐ Mott Haven
☐ Ellenville	☐ Richmond Hill	☐ Myrtle Ave.
☐ Firehouse	☐ Ronkonkoma	☐ Ralph Ave.
☐ Rhinebeck	☐ Long Island City	☐ Other: _____

Insurance Type: ☐ Medicaid ☐ Medicare ☐ HMO ☐ Worker's Compensation

Other Insurance Coverage: _____

Policy Holder ID Number: _____