

Patient Registration Information

Patient Last Name: _____ Patient First Name: _____ MI: _____

Previous Name: *(if applicable)* _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell No: _____ Work Phone: _____ Ext: _____

Email: _____ Date of Birth: _____ Social Security Number: _____

Sex: Male Female Unknown **S.O./G.I. Birth Sex:** Male Female Unknown

Sexual Orientation: Lesbian, gay or homosexual Straight or heterosexual Bisexual Do not know Choose not to disclose
 Something else, please describe _____

Gender Identity: Male Female Female-to-Male (FTM)/Transgender Male/Trans Man
 Male-to-Female (MTF)/Transgender Female/Trans Women Genderqueer, neither exclusively male nor female
 Choose not to disclose Transgender Additional gender category or other, please specify _____

Responsible Party Name: _____ Date of Birth: _____ Relation: _____
(Guarantor) *Last Name* *First Name* *(Guarantor)*

Emergency contact: _____ Relation: _____
Last Name *First Name*

Address: _____ Phone: _____

Marital Status: Divorced Married Partner Single Unknown Widowed Legally Separated

Primary Language: _____ Is a Translator Needed: Yes No

Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American
 White Other Race Other Pacific Islander Declined to Specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to Specify

Release of Information: *(HIPAA form provided and signed)* Yes No RX History Consent: Yes No

Advance Directive: N/A (not applicable) No Yes

Employment: Full-time Part-time Not employed Self-employed Retired Active military duty Unknown

Student Status: Full-time Not a student Part-time

INSURANCE

Primary Insurance: _____ Policy Number: _____

Insured's Name: _____ Patient Relationship to Insured: _____

Secondary Insurance: _____ Policy Number: _____

Insured's Name: _____ Patient Relationship to Insured: _____

Patient's Alternate Name, if applicable (Last, First, MI): _____

Insured's Alternate Name, if applicable (Last, First, MI): _____

Patient Last Name: _____ Patient First Name: _____ Birth Date: _____

PHARMACY (Please include pharmacies you use and indicate which is your Primary pharmacy)

Pharmacy Name and Address: _____ Primary? Yes No

Pharmacy Name and Address: _____ Primary? Yes No

ADDITIONAL INFORMATION

Address: _____ City: _____ State: _____ Zip: _____
(If different than mailing address)

Employer Name: _____ Employer Address: _____

How did you hear about us? Billboard Community event Confinement facility Doctors office Drive by
 Employer Family Friend Health Dept. Health Fair Hospital Insurance/Social Services Internet
 Newspaper Nursing home Outreach Phonebook Postcard Realty company School
 Other (specify) _____

Veteran: Yes No Seasonal farm work: Yes No Migrant farm work: Yes No Homeless: Yes No

If Yes, Homeless Status: Unknown Street Doubling Up Transitional Housing Homeless Shelter Other

Public Housing: Yes No Limited English in speaking, writing or understanding: Yes No

ADDITIONAL CONTACTS

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent and Financial Responsibility Agreement

I/We hereby grant North Florida Medical Center's Inc. (NFMC) permission to treat myself and/or my child/ward for any illness or injury that I/we may encounter. I/We hereby authorize NFMC to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/we agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to NFMC and agree that should I receive any payments directly from any insurance companies for services billed on my behalf by the center, that I will turn those payments over to NFMC immediately. I further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I/We hereby authorize NFMC to act on my behalf in accessing my medical records when and if needed.

Patient's Lifetime Signature or Parent/Legal Guardian

Patient's Name (Print) and Date