COMMONWEALTH PRIMARY CARE, INC.

PATIENT REGISTRATION

DATE: _____

PATIENT REGISTRATION INFORMATION:

In order to meet criteria established by the Federal Government through the Electronic Health Record (EHR) Incentive Program, our Physician Practice must obtain complete demographic data on every patient including preferred language, race, and ethnicity. If you prefer not to answer these questions you may choose to decline. Thank you for your cooperation.

NAME: _____
LAST FIRST MIDDLE SUFFIX

DATE OF BIRTH: _____ **PRIMARY LANGUAGE:** _____

BIRTH SEX: ☐ Male ☐ Female ☐ Unknown ☐ Declined

SEXUAL ORIENTATION: ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ 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 Woman ☐ Genderqueer, neither exclusively male nor female ☐ Choose not to disclose ☐ Additional Gender Category or other, please specify: _____

RACE: ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Declined ☐ Other: _____

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

MARITAL STATUS: _____ **DRIVER'S LICENSE #:** _____ **STATE:** _____

ADDRESS: _____
Address CITY STATE ZIP

HOME PHONE: _____ **MOBILE:** _____ **WORK PHONE:** _____

EMAIL: _____

PHARMACY: _____ **PHARMACY PHONE #:** _____

PHARMACY ADDRESS: _____

EMPLOYER: _____ _____ **OCCUPATION:** _____

EMPLOYER ADDRESS: _____

INSURANCE INFO: Do you request that we file your insurance and authorize your company to pay us benefits directly? ☐ YES ☐ NO

CARRIER: _____ **POLICY HOLDER:** _____

DATE OF BIRTH: _____ **RELATIONSHIP:** _____

POLICY #: _____ **GROUP #:** _____ **EFFECTIVE DATE:** _____

EMERGENCY CONTACT: _____

REFERRING PHYSICIAN: _____