

ADULT PATIENT REGISTRATION FORM

Patient Information

SSN _____

First Name _____ Middle Initial _____

Last Name _____ Preferred Name _____

Suffix _____ Sex at Birth (*check one* ✓): Male Female

Gender Identity (*check one* ✓): Male Female Female to Male/Transgender Male
 Male to Female/Transgender Female Genderqueer/Neither exclusively Male nor Female Other
 Decline to Report

Sexual Orientation (*check one* ✓): Straight or Heterosexual Lesbian, Gay, or Homosexual
 Bisexual Unknown Other Decline to Report

Date of Birth ____/____/____

Marital Status (*check one* ✓): Single Married Divorced Legally Separated Widowed

Race (*check all that apply* ✓): White Black/African American Asian Hispanic/Latino
 American Indian/Alaska Native Native Hawaiian/Pacific Islander Other: _____
 Decline to Report

Ethnicity (*check one* ✓): Latino/Hispanic Not Hispanic or Latino Other Decline to Report

Language Preference: _____

Housing Status (*check one* ✓): Permanent None Unstable Shelter Foster Care
 Institution

Total Estimated Income: _____ Monthly Annual # Household Size: _____

Employment Information

Employment Status: Employed Self-Employed Unemployed Disabled Retired Part-time Student Full-time Student

Employer Name _____ Employer Telephone Number _____



Employment Mailing Address _____

City _____ State _____ Zip _____

Contact Information

Mailing Address _____

City _____ State _____ Zip _____

Email _____

Home Phone _____ Mobile Phone _____ Work

Phone _____ Preferred Phone: Home Cell Work

Preferred Method of Communication: Voice Email Text Don't Contact

May we text you for reminders? Yes No

How did you hear about us? _____

Insurance Information

Do you have insurance? Yes No Name of Insurance Company _____

Policy # _____

Living With _____

Emergency Contact Information

Relationship to Patient _____ First Name _____

Middle Initial _____ Last Name _____ Suffix _____

Mailing Address _____

City _____ State _____ Zip _____

Email _____

Home Phone _____ Mobile Phone _____ Work

Phone _____

Pharmacy Information

Pharmacy _____ Cross Streets _____

The following forms provide you with information about receiving care at Sheridan Health Services. You can receive a copy of each document. Your initials and signature below indicate that you understand the information and agree to the term and conditions outlined below.

_____ **Treatment Consent-** This document allows you and any family members 17 and younger to which you are a parent or legal guardian to receive medical, behavioral health and dental treatment at Sheridan Health Services.

_____ **HIPAA Notice of Private Practices** – The notice provides information on use of your health information. This form outlines when we will release your health information with or without your consent.

_____ **Financial Policy** – This document informs you that Sheridan Health Services expects you to keep your insurance information up-to-date so we may bill for your services when necessary.

_____ **Missed and Late Appointment Policy** – This document informs you that after four (4) or more missed or late appointments, Sheridan Health Services may dismiss you from our care.

Patient/Guardian Signature: _____ Date: _____