Equitas Health
Care for All

PATIENT REGISTRATION FORM

Welcome to Equitas Health!

Thank you for choosing us for your care. To help us serve you better, we kindly request you complete all questions. If you have questions, please let the receptionist know and we will find someone to help.

What is the reason for today's visit?

- ❒ Primary Medical Care
- ❒ HIV Medical Care
- ❒ HIV Testing
- ❒ STI Testing
- ❒ Gender-Affirming Care
- ❒ Post-Exposure Prophylaxis (**PEP**) (I was exposed to HIV)
- ❒ Pre-Exposure Prophylaxis (**PrEP**) (HIV prevention)
- ❒ Support Groups
- ❒ Dental
- ❒ Psychiatry
- ❒ Mental Health Counseling

What should we call you?:

First Name:	**Last Name:**

Legal Name (Required):

First Name:	**Middle Initial:**	**Last Name:**

Date of Birth:	**Month:**	**Day:**	**Year:**	**Social Security Number:**

Street Address:	**Apt. Number:**

City:	**State:**	**Zip:**

My housing is:
- ❒ Permanent
- ❒ Temporary
- ❒ I am experiencing homelessness

We believe it is important to communicate with you, Equitas Health may send mail to the address listed above.

Phone Number

Cell: _____

Home: _____

Work: _____

❒ I consent to receiving text messages.

Patient Portal

The most secure way to communicate with us is through our patient portal. Please show us your identification and provide your email address to get access.

Email address:

❒ I consent to email

Gender Identity:
- ❒ Man
- ❒ Woman
- ❒ Trans Man
- ❒ Trans Woman
- ❒ Genderqueer/ Non-binary
- ❒ _____

Sex Assigned at Birth:
- ❒ Male
- ❒ Female
- ❒ Intersex
- ❒ _____

Do you identify as trans-gender?
- ❒ Yes
- ❒ No

Gender Pronouns:
- ❒ He/Him/His
- ❒ She/Her/Hers
- ❒ They/Them/Theirs
- ❒ _____

Sexual Orientation:
- ❒ Lesbian, Gay, Homosexual
- ❒ Straight, Heterosexual
- ❒ Bisexual
- ❒ Queer
- ❒ _____

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Race:

❒ Alaskan Native/Inuit
❒ American Indian
❒ Asian
❒ Black/African American
❒ Native Hawaiian
❒ Pacific Islander
❒ White/Caucasian

Ethnic Group:

❒ Non-Hispanic/Non-Latino
❒ Hispanic/Latino

Preferred Written/Spoken Language:

❒ English
❒ Spanish
❒ American Sign Language
❒ _____

Do you need language interpretation services?

❒ No
❒ Yes, language _____

Are you hard of hearing or hearing impaired?

❒ Yes
❒ No

Do you have problems with your vision

❒ Yes
❒ No

If you require assistance, please provide type of assistance needed:

_____

To comply with Federal law, we are required to collect information about income and household size from all patients to determine the patient's income by the Federal Poverty Level.

Veteran Status:

❒ Veteran
❒ Not a veteran

How much money do you earn?

$ _____ a year
or
$ _____ a month

❒ I do not have any income

Employment Status:

❒ Full Time
❒ Part Time
❒ Retired
❒ Student
❒ Unemployed
❒ _____

How many people (including yourself) live off your income?

In the past 2 years, has seasonal or migrant farm work been your main source of income?

❒ Migrant
❒ Seasonal
❒ Neither

Emergency Contact Information

First Name:	Last Name:
Relationship:	Phone Number:

Payment and Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION.

Are you insured?

❒ Yes
❒ No

If you do not have insurance, you will meet with the Financial Counselor. You may be eligible for insurance or our sliding fee scale for services. To determine your eligibility, you will provide income, family size, and residency documentation. Until we receive your documentation, you will be responsible for the full fee for your services.

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<table>
<tr><td>Out of Network</td><td colspan="2">Our providers may be out of network for yourinsurance. Choosing to get care with an out of network provider may mean you get charged for the full service and you will have to seek reimbursement from your insurer. Our registration staff can help you understand if our providers are in or out of your network.</td></tr>
<tr><td rowspan="6">Insurance Information:</td><td>Company:</td><td>Member/Subscriber ID:</td></tr>
<tr><td>Group Number:</td><td>Contact Number
(on back of card):</td></tr>
<tr><td>Name on insurance card?
❒ Self
❒ Other

If “other”, please provide the subscriber’s information below</td><td>If private/commercial insurance:
❒ Employer-Paid
❒ Individual-Paid
❒ Other:
_____</td></tr>
<tr><td colspan="2">Name:</td></tr>
<tr><td colspan="2">Social Security Number:</td></tr>
<tr><td colspan="2">Date of Birth:</td></tr>
<tr><td rowspan="2">Secondary Insurance Information:</td><td>Company:</td><td>Identification Number:</td></tr>
<tr><td colspan="2">Contact Number: (on back of card)</td></tr>
<tr><td>Sex/Gender Marker with Insurance Company:</td><td>Equitas Health recognizes your gender identity.
For insurance billing purposes, what sex/gender marker is on file with your insurance company?
❒ Male
❒ Female</td><td>Is your legal name on your insurance card?
❒ Yes
❒ No, it’s listed as
_____</td></tr>
</table>