



PATIENT REGISTRATION (*Falsifying information on this form is grounds for dismissal*)

NAME: _____

FIRST

MIDDLE

LAST

DATE OF BIRTH ____ / ____ / ____ **SOCIAL SECURITY NUMBER** _____
MO DAY YEAR

SEX AT BIRTH: ☐ Male ☐ Female

GENDER IDENTITY: ☐ Male ☐ Female ☐ Transgender Male (Female-to-Male)
☐ Transgender Female (Male-to-Female) ☐ Choose not to disclose

Required for individuals age 18 years and older:

SEXUAL ORIENTATION: ☐ Straight ☐ Lesbian or gay ☐ Bisexual ☐ Other ☐ Don't know
☐ Choose not to disclose

MARITAL STATUS: _____ **Are you a Veteran:** ☐ YES ☐ NO

RELIGIOUS PREFERENCE: _____ **Last grade completed/degree attained:** _____

ETHNICITY: ☐ Non-Hispanic ☐ Hispanic

RACE: (*Please check any that apply*)

☐ White (<i>including</i> Whites of Latino / Hispanic Descent)	☐ Other Pacific Islander
☐ Black / African American	☐ Asian
☐ American Indian / Alaska native	☐ Other _____
☐ Native Hawaiian	

STREET ADDRESS			MAILING ADDRESS (<i>if different</i>)		
_____ <i>HOUSE/APT # STREET</i>			_____ <i>STREET OR P.O. BOX</i>		
_____ <i>CITY STATE ZIP</i>			_____ <i>CITY STATE ZIP</i>		

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER ADDRESS: _____ **WORK PHONE:** _____

EMERGENCY CONTACT: (*person not living with you*)

Name _____ **Relationship to you:** _____

Phone Numbers: _____

Do you have a living will? ☐ Yes (Please provide a copy to your doctor) ☐ No

Information regarding living will is available in the lobby or you may contact your local legal aid office for free information.

Uniform Data System

(Information is required for US Census data collection only. Information is not collected for personal reasons.)

Homeless ☐ Yes ☐ No

Shelter ☐ Yes ☐ No

Public Housing ☐ Yes ☐ No

Annual Household Income _____ **Family Size** _____

Please complete other side

PHARMACY: _____

MEDICAL INSURANCE INFORMATION:

Name of Insurance	Policy Number	Policy Holder

Person to receive bills: ☐SELF or ☐ _____ Relationship to you: _____
NAME

I, _____, hereby authorize Dr. _____ to furnish
information to insurance carriers concerning my diagnosis and treatment.

Signature: _____ Date: _____

HIPAA: AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Required even if no one is listed as authorized)

Authorization of Disclosure of Protected Health Information

Information to be disclosed: ☐Lab results ☐X-ray results ☐Medication info. ☐Appointment info.

Persons authorized to disclose information: ☐Medical Provider ☐Nursing staff ☐Office assistant

Persons to whom information may be disclosed:

This authorization will expire one year after date signed below. To revoke or terminate this authorization, you must submit a written revocation to Ocoee Regional Health Corporation.

*Patient's Signature: _____ Date: _____

Witness (Office Staff): _____ Date: _____

☐Signed by patient representative (If patient is a minor or an adult unable to sign)

FOR PEDIATRIC & ADOLESCENT PATIENTS:

I _____ give Dr.(s) _____ of
print parent/guardian's name name(s) of providers you child sees at this office

Ocoee Regional Health Corporation permission to treat my child _____

Ocoee Regional Health Corporation permission to treat my child without an adult present _____

Signature _____ Date _____

I give the following people permission to bring my child in for treatment:

NOTE: If this information changes any time during the year it is your responsibility to inform us!

Name _____ Relation to child _____

Name _____ Relation to child _____

Name _____ Relation to child _____