PRISM HEALTH

PLEASE READ: Prism Health recognizes all genders and identities; however, many insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex you have listed with your insurance must be used on documents pertaining to insurance and billing. When addressing you, we will always use the name and pronouns that you request to assure that we are using the most respectful language.

Please let us know if there is anything we can do to make your time with us more comfortable. Thank you.

PATIENT REGISTRATION	**TODAY'S DATE:**
Name on file with your insurance Last: First: Middle:	Date of Birth:
Name You Go By: Social Security Number:	Sex Assigned at Birth: ☐Male ☐Female ☐Intersex Legal Sex: ☐Male ☐Female ☐ X
Pronouns You Use: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Hir/Hirs ☐ Ey/Em/Eirs ☐ Xe/Xem/Xyrs ☐ Ve/Vir/Vis ☐ Decline to answer ☐ Name ☐ Other_____	
Gender Identity: ☐ Woman ☐ Man ☐ Transgender ☐ Cisgender ☐ Two-Spirit ☐ Gender Non-Conforming ☐ Non-Binary ☐ Questioning ☐ Decline ☐ Another _____	
Sexual Orientation: ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Asexual ☐ Pansexual ☐ Straight ☐ Questioning ☐ Decline ☐ Another _____	
Relationship Structure: ☐ Single ☐ Monogamous ☐ Polyamorous ☐ Open/Non-Monogamous ☐ Aromantic ☐ Kink/BDSM ☐ Questioning ☐ Decline ☐ Another _____	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Choose not to say ☐ Don't know Race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Middle Eastern/North African ☐ White ☐ Choose not to say ☐ Don't know ☐ Other _____	

Physical Address: City: State:		
Main Phone:	Work Phone:	Other Phone:
Email address:		
Employer: Occupation: Full-time ☐ Part-time ☐		

PRISM HEALTH

INSURANCE INFORMATION (Note: Co-pays are due at the time of service)		
Insurance Name and ID Number:	Who is the insurance subscriber? ☐ Yourself ☐ Someone else	When did your insurance start? Month: Year:

Are you interested in utilizing our **SLIDING SCALE?** If yes, please complete the following. If no, please skip.

Do you make less than $25,760 per year? ☐ Yes, continue ☐ No, Skip the rest ☐ Unsure

Current Annual Income: $_____ Number of people in your household: _____

Source of Income: _____

Estimated annual income:

☐ < 25,760 ☐ 25,520-40,000 ☐ 40,001-75,000 ☐ 75,001-100,000 ☐ >100,000

PREVIOUS PROVIDER INFORMATION

Are you transferring your care from another healthcare provider? ☐Y ☐N

If so, please list the name and phone number of your previous provider.

We will also ask you to fill out a Release of Information so we can obtain your medical records.

Name of Provider: _____

Phone Number: _____

Are you a US Veteran? ☐Y ☐N

EMERGENCY INFORMATION

Emergency Contact Name:_____Relationship:_____

Phone: _____


PRISM
HEALTH