

**NORTH SHORE**



**COMMUNITY HEALTH, INC.**

PATIENT REGISTRATION FORM

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Gender:  Male  Female

Marital Status:  Single  Married  Divorced  Widowed  Separated  Emancipated Minor  Other

Are you a student?  Yes  No If Yes,  Full-time  Part-time

Employment Status:

Full-time  Part-time  Not Employed  Self Employed  Retired  Military Duty  Unknown

Guardian (guarantor), if patient is under 18: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Guardian Address: \_\_\_\_\_

Total household income: \_\_\_\_\_ Total # family members: \_\_\_\_\_

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Patient Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient Ethnicity:  Black/African American  Asian  Caucasian/White  Hispanic/Latino  American Indian  
 Native Hawaiian  Pacific Islander  Other, please specify \_\_\_\_\_

Country of Origin:  USA  Brazil  Portugal  Puerto Rico  Dominican Republic  Albania  
 Other, please specify \_\_\_\_\_

Patient Telephone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Telephone #: \_\_\_\_\_

Primary Care/Usual Provider: \_\_\_\_\_

Primary Language:  English  Spanish  Portuguese  Other, please specify

Highest Level of Education Completed: \_\_\_\_\_

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Residential Information:  Rent  Own  Homeless  Other, please specify \_\_\_\_\_  
If homeless:  transitional  doubling up  street  shelter  other

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Primary Insurance Name: \_\_\_\_\_ Primary Insurance Number: \_\_\_\_\_

Primary Insurance Subscriber (if not patient) Name: \_\_\_\_\_

Primary Insurance Subscriber Social Security #: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Secondary Insurance Number: \_\_\_\_\_

Secondary Insurance Subscriber (if not patient) Name: \_\_\_\_\_

Secondary Insurance Subscriber Social Security #: \_\_\_\_\_

Please read the following carefully before signing

- I agree to let North Shore Community Health, Inc. (NSCHI) and my healthcare provider give information to my insurance company to determine my benefits.
- I agree that NSCHI can submit information from my medical record to my insurance company, Medicare, or other third party payment programs for payment and health related purposes.
- I agree that my insurance company, Medicare, or other third party payment programs may make payments directly to NSCHI.
- I understand I am responsible to pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party program.
- I authorize NSCHI to release my medical information to North Shore Medical Center to allow for the coordination of my health care services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_