Family Health Centers
LONG ISLAND FQHC, INC.
10TH ANNIVERSARY
2009 - 2019
Your Health • Our Mission
Celebrating 10 years of service to Long Island Community

Patient Registration Form

Patient Information

Last Name	First Name	Middle	Home Phone	Primary Contact
			Cell Phone	☐ Home ☐ Cell ☐ Work
DOB / /	SSN#	Country Of Birth	Work Phone	
Mailing Address		Apt#	Ok to leave voice message: ☐ Yes ☐ No Ok to leave a text message: ☐ Yes ☐ No *MSG & data rates may apply	
City	State	Zip	Best time to reach you: ☐ AM ☐PM Opt out of all Practice Communication ☐	
Home Address (If Different from Mailing)			Email Address	
City	State	Zip	Preferred Language	Interpreter Needed? ☐ Yes ☐ No

Emergency Contact

Emergency Contact Full Name	Relationship
Address	Phone Number

We are requesting the following information of all patients in order to understand our patient needs better, to help our staff use the most respectful language when addressing you, and for funding purposes that may help reduce the cost of your healthcare.

Gender at Birth
☐Female ☐Male

Preferred Gender

Marital Status:
☐Single ☐Married
☐Widowed ☐Divorced
☐Separated ☐Partner

Ethnicity- Check one
☐ Hispanic
☐ Non-Hispanic
☐ Unreported/Refused

Housing Status
☐ Own – Private
☐ Rent – Private
☐ Rent – Public Housing (Section 8, NYCHA)
☐Senior Housing
☐ Homeless Shelter
☐ Street
☐ Transitional
☐ Doubling up

Gender Identity: Check as many as apply
☐Male
☐Female
☐Female-to-Male/Transgender
☐Male-to-Female/Transgender
☐Gender queer, neither exclusive male nor female
☐ Choose not to disclose

Sexual Orientation – Check one
☐Straight/ Heterosexual
☐Lesbian/Gay/Homosexual
☐Bisexual
☐Do Not Know
☐Choose Not to Disclose
☐Something else, please describe: _____

Employment Status:
Full Time
☐Part Time
☐Retired
☐Active Military
☐Reserved Military
☐Self Employed
☐Not Employed

Employer Name:

Student:
☐ Full Time
☐ Part Time
☐Not a Student

Race – Check as many as apply
☐ White
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ American Indian
☐ Pacific Islander
☐ Alaskan Native
☐ Other
☐ Unreported/Refused

Are you a:
Veteran ☐ Yes ☐ No
Board Member ☐ Yes ☐ No
LIFQHC employee ☐ Yes ☐ No

How did you hear about us? (Please check one)
☐ Employee
☐ Patient/Friend
☐ Newspaper
☐ Flyer/Poster/Brochure
☐ LIFQHC Event
☐ LIFQHC Website/Internet
☐ Referral
☐Insurance Company
☐Facebook/Social Media
☐Other: _____

Parent/Guardian Information – Please complete if patient is under 18 years of Age				Responsible Party
Mother's Name	DOB / /	Phone	Address	☐
Father's Name	DOB / /	Phone	Address	☐
Guardian's Name	DOB / /	Phone	Address	☐

Insurance Information:		
Primary Insurance Name		Policy #
Name of the Insured ☐ Same as Patient		DOB of Insurance Holder / /
Patient's Relationship to the Insured ☐ Self ☐ Spouse ☐ Child ☐ Other:	Primary Care Provider on Insurance Card	
Secondary Insurance Name:		Policy #

Pharmacy Information		
Pharmacy Name	Phone	Address

Primary Care Provider		
PCP Name	Phone	Address
Advanced Directive: ☐ **Yes** ☐ **No** ☐ **I Decline**		**Living Will:** ☐ **Yes** ☐ **No**

Other Healthcare Providers:		
Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty

I agree to allow Long Island FQHC to contact me regarding my private health information, evaluation, and treatment.

_____ _____

Signature of Patient or Representative Date

I verify that the information above is correct to the best of my knowledge.

_____ _____

Signature of Patient or Representative Date