

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		Date of Birth:	
Last: First:	Middle:		
Name You Go By:	Social Security Number:	Sex Assigned at Birth:	
,	,	□Male □Female □Intersex	
		Legal Sex:	
		□Male □Female □ X	
	She/Her/Hers 🗆 They/Them/Theirs	• • • • • • • • • • • • • • • • • • • •	
$\square$ Xe/Xem/Xyrs $\square$ Ve/Vir/Vis $\square$ Decline to answer $\square$ Name $\square$ 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			
Discorded Addresses			
Physical Address:	to.		
City: Sta			
Main Phone:	Work Phone:	Other Phone:	
Email address:			
Employer:			
Occupation:	Full-time □ Part-time □		



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 <b>SLIDING SCALE?</b> If yes, please complete the following. If no, please skip.			
Current Annual Income: \$ Source of Income: Estimated annual income:	? ☐ Yes, continue ☐ No, Skip the rest Number of people in your ho 0,001-75,000 ☐ 75,001-100,000 ☐	ousehold:	
PREVIOUS PROVIDER INFORMATION			
Are you transferring your care from and	ther healthcare provider? $\Box$ Y $\Box$ 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 □	V		
EMERGENCY INFORMATION			
Emergency Contact Name:	Re	lationship:	
Phone:	<u> </u>		

