orchidhealth
Exceptional, local healthcare

ORCHID HEALTH REGISTRATION FORM

(Please print)

Legal Name: ____**Today's Date:** ________________
First - Middle - Last

Date of Birth (mm/dd/yyyy):_________________________________ **Social Security Number:** ___________________

Preferred name that you go by: _____________________________**Preferred Pronouns:** ______________________

Legal Sex: ☐ **Male** ☐ **Female** ☐ **Other:** ____________

Gender Identity: ☐ **Man** ☐ **Woman** ☐ **Girl** ☐ **Boy** ☐ **Transfeminine** ☐ **Transmasculine** ☐ **Gender Queer** ☐ **Questioning**

☐ **Choose not to disclose** ☐ **Not listed, please tell us:** _______________________________

Current Sexual Orientation: ☐ **Straight** ☐ **Gay or Lesbian** ☐ **Bisexual** ☐ **Questioning** ☐ **Don't know**

☐ **Choose not to disclose** ☐ **Not listed, please tell us:** _________________________________

Physical Address: _________________________________**City:** _______________**State:** _____**ZIP Code:** ___________

Mailing Address: __________________________________**City:** _______________**State:** _____**ZIP Code:** ___________

Home Phone: ____________________**Mobile Phone:** ____________________ **Consent to text?** ☐ Yes ☐ No

Email:___________________________**Preferred communication method:** ________**Preferred Language:** __________

Race: (You can choose more than one if appropriate): ☐ **White** ☐ **Black or African American** ☐ **Asian**

☐ **American Indian or Alaska Native** ☐ **Native Hawaiian or other Pacific Islander**

☐ **Hispanic or Latino Origin** ☐ **Don't know**

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Other ____________________

Emergency Contact Name:_____________________**Relationship:**_____________**Phone Number:**__________________

Relationship Status: ❒ Married ❒ Divorced ❒ Single ❒ Widow(er) ❒ Other Partner

Employment Status: ❒Working ❒ Unemployed ❒ Retired ❒Intentionally Unemployed

What is (or has been) your usual occupation? (type of work)____

INSURANCE INFORMATION

(please bring your insurance card to our receptionist)

Please indicate primary insurance name: ____

Insurance ID #:_______________________________________Group Number:____________________________

Name of SUBSCRIBER: ____________________________SSN: ____________________Date of Birth: ___________________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): ____

Insurance ID #:_______________________________________Group Number:____________________________

Name of SUBSCRIBER: ____________________________SSN: ____________________Date of Birth: ___________________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PERSON Financially Responsible for Bills and Payment:

Relationship to patient: ______________Name: ____DOB: _____________

Mailing Address: _________________________________ZIP Code: ___________City: ________________State: _________

Best Phone Number: ____________________________

** VA PATIENTS ONLY, **MUST** fill in this section **

Policy Holders SS number or DBN number: ____________________ Name of Insurance: __________________________