

ORCHID HEALTH REGISTRATION FORM - MINOR

(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: _____

Parent/legal guardian #1 Name: _____ **Phone:** _____ **Lives with child:** Yes No

Parent/legal guardian #2 Name: _____ **Phone:** _____ **Lives with child:** Yes No

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 Don't know Other _____

Emergency Contact Name: _____ **Relationship:** _____ **Phone Number:** _____

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: _____