ORCHID HEALTH REGISTRATION FORM

(Please print)

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

Preferred name that you go by: _____ **Preferred Pronouns:** _____

Legal Sex: Male/Female/Other **Date of Birth** (mm/dd/yyyy):_____ **Social Security Number:** _____

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

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: _____