



Help-Us Help-U New Patient Registration

Help Us Help You!

We recognize and respect all genders/sexes. However, for insurance and legal purposes, we must use the name and sex on your Photo ID and insurance card. This is necessary for billing and communication with your insurance company. The name on your insurance will be used on all health forms. If you prefer a different name or pronouns, please inform us.

Personal Information:

- Legal First Name: _____
- Last Name: _____
- Preferred Name (Optional): _____
- Date of Birth: _____
- Age: _____
- Social Security Number: _____
- Address: _____
- Address 2 (Optional): _____
- City: _____
- State: _____
- Zip: _____
- Home Phone (Optional): _____
- Mobile Phone (Optional): _____
- Alternate Phone (Optional): _____
- Email Address (Optional): _____
- Notification Preferences:
 - Text Messages: Yes No
 - Email: Yes No
 - Preferred Communication Method:
 - Home Phone
 - Mobile Phone
 - Email
- Assigned Sex at Birth: Male Female
- Pronouns (Optional): _____
- Gender Identity (Optional): _____
- Sexual Orientation (Optional): _____
- Ethnicity (Optional): _____
- Race: (Check all that apply)
 - Black / African-American
 - White
 - American Indian or Alaska Native



- o Asian
 - o Native Hawaiian or Pacific Islander
 - o Other

- Living Arrangements (Please check one):
 - o Permanent Residence (Own, Rent apartment/room/house)
 - o Transitional (center, community, home)
 - o Doubling Up (Living w. other people for a temporary period & move often)
 - o Shelter (Safe haven, temporary overnight Housing, armories)
 - o Street (sidewalk, car, park, doorway, public or abandoned building)
 - o Other (hotel, motel, day-to-day single room occupancy)

- Income (Please check one):
 - o Less than \$14,000
 - o \$14,000 – \$24,999
 - o \$25,000 - \$49,000
 - o \$50,000 - \$74,999
 - o \$75,000 - \$99,999
 - o \$100,000 or more

Marital/Parental/Emergency Contact:

- Marital Status (Optional): _____
- Spouse/Partner/Parent Name (Optional): _____
- Emergency Contact Name: _____
- Emergency Contact Phone: _____

Additional Information:

- Are you a Veteran?: Yes No
- Do you have an Advanced Directive?: Yes No
- Household Annual Income: _____
- Household Size: _____

Payment/Insurance Information:

- Payment Method:
 - o Insurance
 - o Self-pay

- Guarantor:
 - o Self
 - o Spouse
 - o Parent
 - o Other

- Insurance Information (If applicable):



- o Insurance Company Name: _____
- o Plan Name: _____
- o Effective Date: _____
- o Insurance ID: _____
- o Group ID: _____

- Guarantor Information (If other than self):
 - o Guarantor Name: _____
 - o Guarantor's Date of Birth: _____
 - o Guarantor's Social Security #: _____

Primary Care Physician Information:

- Are you becoming a new primary care patient?: Yes No
- Primary Care Physician (If applicable)
 - o Name: _____
 - o Address: _____
 - o Phone: _____
 - o Fax: _____
- Pharmacy Information
 - o Pharmacy Name: _____
 - o Pharmacy Address: _____
 - o Pharmacy Phone: _____

Other:

- How did you hear about Help-Us Help-U? (Optional): _____
- PHYSICIANS (other than PCP) that you are currently receiving medical care from:
(Optional)
 - o Physician Name: _____
Phone Number/Fax: _____
Specialty and Reason: _____
 - o Physician Name: _____
Phone Number/Fax: _____
Specialty and Reason: _____
 - o Physician Name: _____
Phone Number/Fax: _____
Specialty and Reason: _____



- **CURRENT MEDICATIONS:** prescribed or over the counter (i.e. aspirin, Claritin):

Driver's License or or ID proof Upload:(Front and Back) Yes No

(Front)

(Back)

Insurance Card Upload: (Front and Back) Yes No

(Front)

(Back)

Patient Signature: _____ **Date:** _____

Thank you for choosing Help-Us Help-U. We look forward to serving you!

Please note: This form is designed to gather essential information for your new patient registration. All information provided will be kept confidential and used solely for the purpose of providing you with the best possible care. If you have any questions or concerns, please do not hesitate to ask.