easterseals
Capital Region & Eastern Connecticut

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full Legal Name: _____ **Date of Birth**: _____

Preferred Name (if different): _____

Address: _____

Primary Phone: _____ ☐ Cell ☐ Home ☐ Work

Secondary Phone: _____ ☐ Cell ☐ Home ☐ Work

Email: _____

Preferred Method of Contact (check all that apply): ☐ Phone ☐ Text ☐ Email ☐ Mail

☐ I consent to receive text messages about appointments and care (*message/data rates may apply)*.
☐ I give permission to leave appointment reminders via voicemail/text

PARENT / GUARDIAN / CONSERVATOR (*if applicable*)

☐ Check if this person is the **primary contact** for patient

Name: _____ ☐ Parent ☐ Guardian ☐ Conservator ([ ] Person [ ] Estate)

Phone: _____ **E-Mail**: _____

Legal Documentation Provided (e.g., copy of guardianship, conservatorship, etc.)? ☐ Yes ☐ No ☐ N/A

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group # _____

Is the patient the policy holder? ☐ Yes ☐ No

If no, Subscriber's name: _____ DOB: _____

Relation to the Patient: ☐ Parent ☐ Spouse ☐ Other: _____

Secondary Insurance: _____ Policy #: _____ Group # _____

Is the patient the policy holder? ☐ Yes ☐ No

If no, Subscriber's name: _____ DOB: _____

Relation to the Patient: ☐ Parent ☐ Spouse ☐ Other: _____

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EMERGENCY INFORMATION

Emergency Contact Name: _____ **Phone**: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other: _____

Primary Care Provider (PCP) Name: _____ **Phone**: _____

Preferred Hospital (if any): _____

Current Medications, including over-the-counter (attach separate page if needed):

_____

_____

Allergies: _____

HOW DID YOU HEAR ABOUT US? (Please check all that apply)

☐ Doctor or healthcare provider ☐ Family or friend ☐ Social Media ☐ Online search ☐ School

☐ Community event ☐ Insurance company/provider directory ☐ Other: _____

BASIC NEEDS ASSESSMENT SCREENING (OPTIONAL)

In the past 12 months, have you had concerns about any of the following (check all that apply):

☐Food security	☐Utilities (e.g., heat, electricity)	☐Personal safety
☐Housing stability	☐Childcare	☐None of the above
☐Transportation access	☐Access to healthcare	

Would you like assistance or referrals for any of the above needs? ☐ Yes ☐ No

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DEMOGRAPHICS (OPTIONAL)

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other: _____ ☐ Prefer not to answer

Sex assigned at birth: ☐ Male ☐ Female ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to say

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ Prefer not to say

Military Status:☐ Active Duty ☐ National Guard/Reserve ☐ Veteran ☐ Dependent ☐ N/A ☐Prefer not to say

Disability Status (Do you identify as a person with a disability?): ☐ Yes ☐ No ☐ Prefer not to say