WAKE COUNTY NORTH CAROLINA Human Services

Patient Registration GE Centricity

Patient ID# / MR#: _____ Registration Site:_____ Social Security #:_____

Date of Birth: _____ **Sex:** ☐ M ☐ F Transgender: ☐ Yes ☐ No

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Choose not to disclose

First Name: _____ Middle: _____ **Last:** _____

Address: _____ **Email:** _____

City, State, Zip: _____

Home Phone: _____ Ok to call: ☐ Yes ☐ No Ok to leave message: ☐ Yes ☐ No

Cell Phone: _____ Ok to call: ☐ Yes ☐ No Ok to leave message: ☐ Yes ☐ No

Work Phone:_____ Ok to call: ☐ Yes ☐ No Ok to leave message: ☐ Yes ☐ No

Preferred Contact method: ☐ Phone ☐ Email ☐ Letter ☐ Text message

Primary Language: ☐ English ☐ Spanish ☐ Arabic ☐ Mandarin ☐ Sign ☐ Vietnamese ☐ Korean

☐ Other- please list: _____ Requires Translation: ☐ Yes ☐ No

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian

☐ American Indian /Alaskan Native ☐ Other Pacific Islander ☐ Other/Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Marital Status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact: Name_____ Phone #_____

Relationship to patient: _____ Does this person know you are a patient: ☐ Yes ☐ No

Sliding Fee Information: Family Size: _____ Monthly Income: _____

Verification Source: _____ Sliding Fee Class: _____% Pay ☐ Refused to Provide

Guarantor Information:

First Name: _____ Middle: _____ Last: _____

Address: _____

Phone: _____ Date of Birth: _____ Patients Relationship to Guarantor: _____

Primary Insurance:

Insured Party: _____ ☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Phone: _____ Date of Birth: _____

Insurance Company: _____ Insurance ID#: _____

Policy/Group#:_____

Secondary Insurance:

Insured Party: _____ ☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Phone: _____ Date of Birth: _____

Insurance Company: _____ Insurance ID#: _____

Policy/Group#: _____

Pharmacy Name: _____ **Phone:** _____

Pharmacy Address: _____

Upon penalties prescribed by law, I hereby affirm that to the best of my knowledge and belief this information is true and correct.

Signature_____ Date_____

Witness Signature_____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____hereby acknowledge that I have received a copy of the Wake County Notice of Privacy Practices.

Signature_____Date_____