NEW PATIENT REGISTRATION

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

Phone: 207-874-2141 Fax: 207-874-2164

PATIENT NAME & CONTACT

LEGAL LAST NAME _____

LEGAL FIRST NAME _____

LEGAL MIDDLE NAME _____

PREFERRED FIRST NAME _____
chosen name, nickname, goes-by name, "Please call me by this name"

DATE OF BIRTH ___/___/___
Month Day Year

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER: ___-___-___

☐ Social Security ☐ Alien Registration Number (I-94 Number from US Gov't) ☐ None

Mailing/Billing Address

Street Address _____

City _____

State _____ **Zip Code** _____

Email Address _____

Are you interested in our Patient Portal?

☐ YES ☐ NO

Phone Numbers

OK to leave a detailed message?
Please circle yes or no next to each phone number provided

Home Phone _____ ☐ YES ☐ NO

Work Phone _____ ☐ YES ☐ NO

Cell Phone _____ ☐ YES ☐ NO

My preferred contact method is:

☐ Home ☐ Work ☐ Cell ☐ WhatsApp

FOR OFFICE USE ONLY

Provider:

Insurance:

Appointment Date/Time:

ID: ☐ Scanned ☐ Copied

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PATIENT INFORMATION

The information you share in this section will not negatively affect your care in any way. It is for demographic purposes only.

Legal Sex (check one):
☐ Male
☐ Female

Is there anything else you would like to share with us about your background that could affect how we care for you as a patient? _____
_____
_____

Race:

☐ **White**
Portugal, Germany, Poland, Bosnia, Middle Eastern Countries

☐ **Black, African, African-American**
Haiti, Jamaica, Kenya, Congo, etc.

☐ **Pacific Islander**
Samoa, Guam, Micronesia, Tahiti, Palua, etc.

☐ **Asian**
China, Philippines, Bangladesh, Nepal, Pakistan, Vietnam

☐ **Native Hawaiian**
Native of any Hawaiian Island

☐ **South/Central/North American Indian, Alaska Native**
Native American, Penobscot, Passamaquoddy, Maliseet, Micmac, Abenaki, Inuit, Mayan, Puerto Rican, Miskito, Chatino, etc.

☐ **Multiracial**
More than one race/ethnicity

☐ **Declined to Specify**

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Check any living situation you have experienced in the last 12 months:

☐ **Own a Home**

☐ **Rent**

☐ **Shelter** ***(Homeless Service Center, Family Shelter, Milestone Detox Center, etc.)***

☐ **Street** ***(Living in automobile, tent, abandoned building, etc.)***

☐ **Transitional Housing** ***(Logan Place, Florence House, Huston Commons, SARC, Milestone Residential Treatment, etc.)***

☐ **Doubling Up** ***("Couch surfing," living with family or friends)***

Public Housing
Do you have housing subsidized by public funds (section 8)?

☐ **YES**

☐ **NO**

Employment Status
☐ Full-Time
☐ Part-Time
☐ Unemployed
☐ Self-Employed
☐ Disabled
☐ Student

Are you a Migrant or Seasonal Farm Worker?
☐ Seasonal
☐ Migrant
☐ Not a Farm Worker

Total Household Income
(Fill in only one please)

Weekly: $_____

Monthly: $_____

Annual: $_____

☐ **Check the box if you decline to answer**

Benefits
(SSI/SSDI, Unemployment, etc.; please fill in only one)

Weekly: $_____

Monthly: $_____

Annual: $_____

☐ **Check the box if you decline to answer**

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PATIENT INFORMATION (CONTINUED)

Financial Assistance Program (Check all that apply to you):

☐ MaineHealth Free Care Program—Expiration Date: _____ ☐ General Assistance

☐ Northern Light (Mercy) Free Care—Expiration Date: _____ ☐ CarePartners

Total# of adults living in the household: _____
Total# of children living in the household: _____
Total# of family members living in household: _____

Do you have an Advanced Directive or Living Will?
☐ **YES** ☐ **NO**
*If yes, please bring it with you to your next visit.

What is your country of origin? _____

Preferred Language (Choose One):

☐ English ☐ Spanish ☐ French ☐ Arabic ☐ Portuguese ☐ Somali ☐ Cantonese ☐ Lingala

☐ ASL (Hearing Impaired) ☐ Kinyarwanda ☐ Kirundi ☐ Swahili ☐ Other:_____

Do you require an interpreter? ☐ **YES** ☐ **NO**

Are there any accommodations you might need during your health care visits with us?
We will do our best to accommodate you whenever possible. Please speak to your provider or the front desk staff for help.
Please describe:

Have you ever served in any branch of the United States Military, Armed Forces or Uniformed Services?
This includes Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves or the U.S. Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA). ☐ **YES** ☐ **NO**

How did you hear about Greater Portland Health? _____

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INSURANCE COVERAGE

I Have Medicaid/Medicare:

☐ MaineCare: _____ _____
(Medicaid) MaineCare ID# Name of Insured Person

☐ Medicare: _____ _____
Medicare ID# Name of Insured Person

I Have Commercial/Private Insurance:

_____ ___/___/___ _____
Name of Subscriber Date of Birth Relationship to Patient

_____ _____ _____ _____
Name of Insurance Company Member ID # Group ID # Effective Date

_____ _____ _____ _____
Address City State Zip

I Do Not Have Insurance, I am Uninsured.

Please select one option below:

☐ **I do *not* have health insurance and I wish to apply for the Financial Assistance Program at Greater Portland Health.**

☐ **I do *not* have health insurance and I *do not* wish to apply for financial assistance. I understand that I am financially responsible for all charges incurred by me.**

LEGAL GUARDIAN/EMERGENCY CONTACT/SUPPORT ROLE INFORMATION

1.)_____ _____ _____ _____
Last Name First Name Relationship/Role Date of Birth

_____ _____ *Patient of Greater Portland Health ?
Address Telephone # ☐ **YES** ☐ **NO**

2.)_____ _____ _____ _____
Last Name First Name Relationship/Role Date of Birth

_____ _____ *Patient of Greater Portland Health?
Address Telephone # ☐ **YES** ☐ **NO**

_____ _____
Signature of Patient or Parent/Legal Guardian **Date Signed**