ZUFALL HEALTH COMMUNITY HEALTH CENTERS

PATIENT REGISTRATION
(Registro de Paciente)

Today's *Date* *(Fecha de hoy)*: ____________

Legal Name (Nombre Legal):

Preferred Name (Nombre Preferido):

Pronouns (Pronombres):
☐She/her/hers (ella) ☐He/him/his (él) ☐They/them/theirs (elle) ☐Other (otro):

Address (Dirección): | **City (Ciudad):** | **State (Estado):** | **Zip (Codigo postal):**

Phone numbers (Números de Teléf.) **Home (Casa):** **Cell (Celular):**

Birth Date (Month/Day/Year): Fecha de Nacimiento (Mes/Día/Año):

Sex at birth (Sexo al nacer):
☐Male (Hombre) ☐Female (Mujer)

Country of Birth (País de nacimiento):

Date of Arrival to USA (Fecha que llegó a EEUU):

Marital Status (Estado civil):
☐Single (Soltero) ☐Separated (Separado) ☐Married (Casado)
☐Divorced (Divorciado) ☐Widowed (Viudo) ☐Living together (Viviendo juntos)

Responsible Party (Persona responsable): ☐Self (Yo mismo) ☐Parent/Guardian (Padre/ Guardián):

Emergency Contact Name (Nombre del contacto de emergencia):
Phone # (Teléfono):

Relationship to patient (Relación con el paciente):

Email Address (Correo electronico):

Preferred language (Idioma preferido):

Need translation? (¿Necesita un traductor?)
☐Yes (Sí) ☐No

Race *Check ALL that apply (Raza *Marque TODAS las que correspondan):
Definitions of race available upon request (Descripciones de cada raza están disponibles a su solicitud)

☐Asian Indian
☐Chinese
☐Filipino
☐Japanese
☐Korean
☐Vietnamese
☐Other Asian
☐Native Hawaiian (Nativo de Hawái)
☐Other Pacific Islander (De otras islas del Pacífico)
☐Guamanian or Chamorro
☐Samoan
☐Black/African American (Negro/Afroamericano)
☐American Indian/Alaska Native (Indio Americano/Nativo de Alaska)
☐White (Blanco)
☐Decline to specify (Negar contestar)

Ethnicity *Check ALL that apply (Etnicidad *Marque TODAS las que correspondan):

☐Mexican, Mexican American, Chicano/a
☐Puerto Rican
☐Cuban
☐Another Hispanic, Latino/a or Spanish origin (Otra etnicidad hispana/latina)
☐Not Hispanic, Latino/a, or Spanish origin
☐Decline to specify (Negar contestar)

Sexual orientation (Orientación sexual):

☐Straight/heterosexual (Heterosexual)
☐Lesbian/gay/homosexual (Lesbiana/gay/homosexual)
☐Bisexual (Bisexual)
☐Other, sexual orientation not listed (Otra orientación sexual no mencionada)
☐Do not know (No lo sé)
☐Choose not to disclose (Negar contestar)
☐Something else, please describe (Otra orientación sexual, por favor descríbala):

Gender identity (Identidad de género):

☐Male (Hombre)
☐Female (Mujer)
☐Gender non-conforming (Género no binario/no binarie)
☐Other, gender identity not listed (Otra identidad de género no mencionada)
☐Male-to-female transgender (Hombre a mujer - transgénero)
☐Female-to-male transgender (Mujer a hombre - transgénero)
☐Choose not to disclose (Negar contestar)
☐Something else, please describe (Otra orientación sexual, por favor descríbala):

Pharmacy Name (Nombre de su farmacia):
Address (Dirección):

Pharmacy Phone # (Teléf. de su farmacia):

Please continue form on Page 2 (Continúe con el formulario en la página 2) ➔

Employer (Empleador):	Occupation (Ocupación):

Is patient/parent/guardian employed? (¿Está empleado el paciente/padre/guardián?)	☐No ☐Yes/Sí, $__________ Income/benefits from any source (Ingresos/beneficios de cualquier fuente) ☐(Weekly/Semanal) ☐(Biweekly/Quincenal) ☐(Monthly/Mensual) ☐(Yearly/Anual)
Spouse Employed? (¿Está empleado su esposo/a?)	☐No ☐Yes/Sí, $__________ Income/benefits from any source (Ingresos/beneficios de cualquier fuente) ☐(Weekly/Semanal) ☐(Biweekly/Quincenal) ☐(Monthly/Mensual) ☐(Yearly/Anual)

Total Family Income (Ingreso Total Familiar): $_________ ☐N/A ☐(Weekly/Semanal) ☐(Monthly/Mensual) ☐(Yearly/Anual)	**Family Size (Tamaño de su Familia):** _____Adults (Adultos) _____Children (Niños)

I certify that the above information is true and accurate to the best of my knowledge. (Certifico que la infomación anterior es verdadera y correcta según mi entendimiento.)

____ __________ ____ __________

Signature of Patient (Parent or Guardian) **Date (Fecha)** **Signature of minor 13 or over** **Date (Fecha)**
Firma del paciente (Padre o guardián) **(Firma de un paciente entre 13 a 18 años de edad)**

TO BE COMPLETED BY ZUFALL HEALTH REPRESENTATIVE
(Este lado será completado por un representante del centro de salud)

Patient Status:
☐Veteran ☐Public Housing
☐Homeless ☐Farm Worker

Health Insurance:
☐None (uninsured) ☐Commercial
☐Medicare ☐Other:
☐Medicaid _______________

Proof of Address:
☐Utility Bill ☐Letter of Support
☐Mortgage ☐Other:
☐Copy of Lease _______________

Proof of ID:
☐Birth Certificate ☐Voter Registration Card
☐NJ Driver License ☐Employee ID Card
☐Passport ☐Welfare Card
☐Alien Registry Card ☐Other: _______________

Proof of Income: (Check all that apply)
☐Paycheck ☐Attestation (Proof of Income Form)
☐Disability Benefit ☐Unemployment Benefit
☐Statement from Employer ☐Income Tax Return
☐Child Support ☐Social Security
☐Alimony ☐Other: _______________

2023 Federal Poverty Level Guidelines						
	Federal Slide & NJDHSS	**Federal Slide & NJDHSS**	**Federal Slide & NJDHSS**	**Federal Slide & NJDHSS**	**NJDHSS eligible only**	**NOT eligible for Federal or NJDHSS slide**
	A	**B**	**C**	**D**	**E**	
Family Size*	**up to 100%**	**101% to 150%**	**151% to 175%**	**176% to 200%**	**201 to 250%**	Full charge or Prompt Pay Incentive
1	$0 to 14,580	14,581 to 21,870	21,871 to 25,515	25,516 to 29,160	29,161 to 36,450	
2	$0 to 19,720	19,721 to 29,580	29,581 to 34,510	34,511 to 39,440	39,441 to 49,300	
3	$0 to 24,860	24,861 to 37,290	37,291 to 43,505	43,506 to 49,720	49,721 to 62,150	
4	$0 to 30,000	30,001 to 45,000	45,001 to 52,500	52,5001 to 60,000	60,001 to 75,000	
5	$0 to 35,140	35,141 to 52,710	52,711 to 61,495	61,496 to 70,280	70,281 to 87,850	
6	$0 to 40,280	42,281 to 60,420	60,421 to 70,490	70,491 to 80,560	80,561 to 100,700	
7	$0 to 45,420	45,421 to 68,130	68,131 to 79,485	79,846 to 90,840	90,841 to 113,550	
8	$0 to 50,560	50,561 to 75,840	75,841 to 88,480	88,481 to 101,120	101,121 to 126,400	

***For families/households with more than 8 persons, add $5,140 for each additional person.**

☐NO INCOME; Patient and/or Family Living/Staying with: ☐Family ☐Friend ☐Agency __________ ☐Other
Statement of support must be on file. *Staff enters into structured info section.

____ ____________________
Signature of Zufall Health Representative Date