WMC Health | Westchester Medical Center
Westchester Medical Center Health Network

ADO038

PATIENT REGISTRATION SUPPLEMENTAL FORM

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The information in your medical record is confidential and protected under New York State and Federal laws and regulations including but not limited to, New York State Regulation 10 CRR-NY 405.7 and the Federal law, Health insurance Portability and Accountability Act (HIPAA). Usually your written consent will be required for the release of your medical information

Medical Record #:
(for office use only)
_____

Patient Registration Supplemental Form

Legal Name: Last **First** **M.I.** **Name in Use:**

Legal Sex ☐ Female ☐ Male

While Westchester Medical Center Health Network facilities recognize a number of gender identities, many insurance companies and legal entities do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your name in use/preferred name and pronouns are different from these, please let us know.

Sex Assigned at Birth:
☐ Female
☐ Male

Relationship Status:
☐ Single ☐ Divorced
☐ Widowed ☐ Married
☐ Partnered

Veteran Status:
☐ Veteran
☐ Not a Veteran

Race(s):
Select All That Apply

☐ American Indian
☐ Asian Indian
☐ Bangladeshi
☐ Black or African American
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorra
☐ Hispanic Black
☐ Hispanic Other
☐ Hispanic White
☐ Hmong
☐ Japanese
☐ Korean

Race(s):
Select All That Apply

☐ Laotian
☐ Native Hawaiian or Pacific Islander
☐ Other Pacific Island
☐ Other Race
☐ Pakistani
☐ Patient Declined
☐ Samoan
☐ Taiwanese
☐ Thai
☐ Unavailable
☐ Vietnamese
☐ White

Ethnic Group(s):
Select All That Apply

☐ Argentinian
☐ Colombian Cuban
☐ Dominican
☐ Ecuadorian
☐ Guatemalan
☐ Honduran
☐ Mexican/Mexican American
☐ Nicaraguan
☐ Nicaragua
☐ Non-Hispanic
☐ Patient Declined
☐ Peruvian
☐ Puerto Rican
☐ Salvadoran
☐ Spaniard
☐ Unavailable
☐ Venezuelan

For Pediatric Patients:
Parent/Guardian Name:
(Please Print)

Completion of the section below is voluntary and the information will be used for demographic purposes and the provision of healthcare services

Pronouns (i.e., she/her/hers; he/him/his, they/them/theirs):

Gender Identity:
☐ Female
☐ Male
☐ Female to Male Transgender
☐ Male to Female Transgender
☐ Gender queer (not exclusively male or female)
☐ Decline to Answer
☐ Other (Please list)

Sexual Orientation:
☐ Lesbian/Gay
☐ Heterosexual
☐ Bisexual
☐ Unsure
☐ Decline to Answer
☐ Other (Please list)

OFFICE USE ONLY
☐ Patient is unable to complete due to condition
☐ Patient declined

_____ Hospital Staff Person's Name

_____ Date / Time