WMC Health
Westchester Medical Center Health Network

What is the Supplemental Form?

Supplemental Form- Below, the patient/patient's representative will enter the patient's preferences. The patient or patient's representative can decline to complete the form.

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
- ☐ Nicaraguan
- ☐ Non-Hispanic
- ☐ Patient Declined
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Spaniard
- ☐ Unavailable
- ☐ Venezuelan

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

WMC Health
Westchester Medical Center Health Network

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 ☐ Genderqueer (*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 – The Registration Representative will select **one** option when the patient either refuses or is unable to sign due to medical condition. The Registration Representative will sign and indicate date and time of signature.

OFFICE USE ONLY:

☐ Patient is unable to complete due to condition

☐ Patient declined

_____ _____

Hospital Staff Person's Name Date & Time