

### Patient Information

Full Legal Name		Date of Birth	Social Security Number	Marital Status
Street Address		City	State	Zip Code
Primary Phone Number	Secondary Phone Number	Email Address		
Religion	Primary Care Provider	Clinic		
Employer	Employer's Address	Employer's Phone Number		

### Primary Emergency Contact

Name	Primary Phone Number	Secondary Phone Number	Relationship to Patient
Street Address	City	State	Zip Code

### Insurance Information

<b>Primary Insurance Name</b>	Insurance Policy Number	Insurance Group Number	
Insurance Subscriber (who carries insurance)	Date of Birth	Social Security Number	
Street Address	City	State	Zip Code
Primary Phone Number	Secondary Phone Number	Relationship to Patient	

Would you like access to **MyHealth Info**, a 24/7 online access point for your Northfield Hospital & Clinics health info, lab results, messaging your provider, etc.?

Yes, please sign me up (an email address must be provided above)       I already have access       Decline

Do we have your permission to release your baby's name and information to the radio/newspaper?       Yes       No

Do you wish to receive phone calls and visitors while you are here in the hospital?       Yes       No

Are you open to receiving a visit from clergy if he/she is in our facility?  Yes Faith/Church\_\_\_\_\_  No

**We are required by state and federal law to obtain the following information regarding your origin, race, ethnicity, and preferred language. Your answers will help us provide the best care for all of our patients. The information provided will be kept private and confidential.**

**Country of Birth:** \_\_\_\_\_ **Preferred Language:**     English     Other: \_\_\_\_\_

**Ethnicity:**     Hispanic or Latino     Non-Hispanic or Latino

**Race (please check all that apply):**

- White     Black or African American     Asian     Native Hawaiian or other Pacific Islander  
 American Indian or Alaskan Native     Choose not to disclose     Unknown