MEDICAID PATIENT REGISTRATION
FORM

CrossOver Healthcare Ministry

Have you been a patient at CrossOver?: YES NO

PATIENT INFORMATION

Last Name: First Name: M.I.:

SSN: DOB: Gender: Male Female Other

Mailing Address: Apt #:

City/State/Zip:

Home Phone: Cell Phone: Email:

Preferred Method of Contact: Voice: Text: Email: Marital Status:

Emergency Contact Name: Emergency Contact Phone:

Emergency Contact Relationship to Patient: How were you referred?:

ADDITIONAL INFORMATION

Highest Level of Education: Occupation:

Employment: Full-Time Part-Time Dependent Disabled
Retired Student Unemployed Seasonal

Race: White Hispanic American Indian or Alaskan Native
Asian Black/AA Native Hawaiian or Pacific Islander
Decline Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino Religion: Decline

Country of Origin: Years in the U.S.: Years: Months:

Preferred Language: English Spanish Portuguese French Arabic Other

HOUSING & LIVING SITUATION

***Please** list the names and relationships of the patient's family unit living in the house.*

Housing: House Apt./Townhome Trailer Room Rental Shelter Homeless

Name	DOB	Relationship to Patient

INSURANCE INFORMATION

Preferred Pharmacy Name:

Preferred Pharmacy Location:

Preferred Pharmacy Phone:

Are you insured under a non-Medicaid plan?

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	**Ins. Co. Name:**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder's DOB:	**Policy Holder's DOB:**
Member ID:	**Member ID:**
Patient Relationship to Policy Holder:	**Patient Relationship to Policy Holder:**

SIGNATURE

Signature of Responsible Party: ______________________

Date:

Printed Name of Responsible Party: ______________________

Date:

More Information :
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