NIH CLINICAL CENTER
AMBULATORY CARE SERVICES PATIENT REGISTRATION FORM – OFFSITE VISIT

*Required Field

Patient Information

*Name: _____ *Date of Birth: ___/___/_____
Last First Middle

SSN: ___-___-_____ *Sex: _____ Marital Status: _____

*Address: _____

*City: _____ *State: _____ *Zip Code: _____ Country: _____

* (a contact #) Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: (for secure email communication with provider if provider elects to): _____

Primary Language: _____ *Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Religious Preference: _____ *Race (check one):

If admitted would you like a Clergy visit: ( ) yes ( ) no

Country of Citizenship: _____

☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Hawaiian/Pacific Island
☐ Multiple Race
☐ Unknown
☐ White

Supplemental Information

How were you referred to the NIH (check one)

☐Self Referral (select one below)

How did you hear about the NIH:

☐Family/Friend
☐Physician
☐Media
☐Newspaper/Magazine
☐Internet
☐Flyers/Mailings
☐Community Outreach

☐Physician Referral (complete referring physician information)

Name: _____

Address: _____

_____

City: _____ State: _____

Zip Code: _____

Phone: _____

Fax: _____

Are you employed by the NIH? ( ) no ( ) yes

Are you related to a NIH employee? ( ) no ( ) yes If yes, relationship to employee: _____

How would you like to be notified of follow-up appointments? ( ) Mail ( ) Phone ( ) Mail & Phone ( ) None

Do you have a Private Physician: ( ) no ( ) yes

Are you employed by: ( ) Government ( ) Self Employed ( ) Private ( ) Other: _____

NIH CLINICAL CENTER
AMBULATORY CARE SERVICES PATIENT REGISTRATION FORM – OFFSITE VISIT

Contact Information

***Next of Kin:** _____ **Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

***Emergency contact:** _____ **Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Physician/Dentist to Receive Reports (Doctor Outside the NIH) - Complete if you would like for your doctor(s) outside the NIH to receive your medical reports from the NIH.

Physician's Name: _____ **Specialty:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Office Phone: _____ **Fax:** _____

Physician's Name: _____ **Specialty:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Office Phone: _____ **Fax:** _____

Information Provided by: _____ **Relationship to Patient:** _____