OPTUM®

Patient registration 1

☐ **New patient** ☐ **Established patient/updates**

Patient information (Please Print)

Last name: _____ First: _____ Middle: _____

Other name(s) you are also known as: _____ DOB: ____/____/____

Gender Identity: ☐ Man ☐ Woman ☐ Nonbinary ☐ Genderqueer
☐ Prefer not to disclose ☐ Other: _____

Sex assigned at birth: ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to disclose ☐ Other: _____

Relationship status: ☐ Single ☐ In a relationship ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Driver's license number.: _____

Religious affiliation: _____

Required information

Home address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Phone numbers (please check box of your preferred contact number)

☐ Home: _____ ☐ Cell: _____

☐ Work: _____ Ext: _____

Email: _____

☐ In addition to gaining access to the online health portal, I would like to receive occasional emails with information to help me better manage my health.

Emergency contact

Last name: _____ First: _____ Relationship: _____

Home address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Home: _____ Cell: _____ Work: _____ Ext: _____

Required Information

Ethnicity (Select one): ☐ Hispanic or Latino or Spanish origin ☐ Prefer not to disclose
☐ Not Hispanic, Latino or Spanish origin

Race (Select one): ☐ American Indian-Alaska native ☐ Asian
☐ Black or African American ☐ White or Caucasian
☐ Native Hawaiian or Pacific Islander ☐ Prefer not to disclose

Primary language: _____

Employer information

Employer: _____ Date employed: _____

Street address: _____ Suite: _____

City: _____ State: _____ ZIP: _____

Occupation: _____

Have you ever been a patient in any Optum facility before? ☐ Yes ☐ No

If yes, state the location/provider: _____

Responsible party information (do not complete if patient is responsible party)

Relationship to patient: _____

Last name: _____ First: _____ Middle: _____

Driver's license number: _____ DOB: ____/____/____

Home address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Email: _____

Home: _____ Cell: _____ Work: _____ Ext: _____

Health plan information

Primary insurance

Health plan: _____ Eff. date: _____

ID no: _____ Plan: _____ Group no: _____

Subscriber: _____ Phone: _____

Insurance address: _____

Secondary insurance

MediCal identification number: _____

Spouse/other parent's health plan: _____ Eff. date: _____

ID no: _____ Plan: _____ Group no: _____

Subscriber: _____ Phone: _____

Insurance address: _____

_____ _____

Form completed by (print) Date

X _____ _____

Signature Relationship to patient

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Employer information

Employer: _____ Date employed: _____

Street address: _____ Suite: _____

City: _____ State: _____ ZIP: _____

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City: _____ State: _____ ZIP: _____

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Home: _____ Cell: _____ Work: _____ Ext: _____

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Primary insurance

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ID no: _____ Plan: _____ Group no: _____

Subscriber: _____ Phone: _____

Insurance address: _____

Secondary insurance

MediCal identification number: _____

Spouse/other parent's health plan: _____ Eff. date: _____

ID no: _____ Plan: _____ Group no: _____

Subscriber: _____ Phone: _____

Insurance address: _____

_____ _____

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X _____ _____

Signature Relationship to patient

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