REGISTRATION FORM

To the Patient: *Please complete this registration from, and return it to the hospital as soon as possible. A portion of this information is needed to complete your baby's birth certificate, therefore, accuracy is important. Please use current legal names in all cases. Thank you.*

Patient Last Name (Baby's Mother) First Middle	Preferred Name	Patient's Date of Birth
Home Phone:	Cell Phone:	Patient's Place of Birth - City/Town, State/Country
Patient Address – Street City State Zip		Have you ever received medical services at BWH? Y or N BWH Medical Record # (if known)
Mailing Address (if different from above)		Patient Email:
Marital Status – **Please Circle One** Declined Married/Civil Union Single Legally Separated Life Partner Divorced Unavailable Widowed	Which of the following best describes your Gender Identity? ☐ Female ☐ Queer / Genderqueer ☐ Male ☐ Questioning / Unsure ☐ Other ☐ Transgender Female / Male-to-Female ☐ Transgender Male / Female-to-Male	Which of the following best describes your sexual orientation? ☐ Bisexual ☐ Pansexual ☐ Choose not to disclose ☐ Queer ☐ Don't know ☐ Something else ☐ Lesbian or Gay ☐ Straight (not lesbian or gay)
Patient Employer Name Phone:	Veteran Status ☐ Declined ☐ No, Never Served or Is Currently Active ☐ Not Applicable - Under the Age of 18 ☐ Unavailable ☐ Yes	Employment Status: ☐ On Active Military Duty ☐ Self Employed ☐ Homemaker ☐ Part Time ☐ Student - Full Time ☐ Not Employed ☐ Retired ☐ Student - Part Time
Next of Kin _____ Do you wish to have this person notified of your admission to the hospital? ☐Y ☐N Do you wish to designate this person as a caregiver who will receive medical information related to your discharge planning? ☐Y ☐N	Relationship to Patient	Next of Kin Telephone Number(s)
Next of Kin (in case of emergency) If other than spouse /significant other: _____ Do you wish to have this person notified of your admission to the hospital? ☐Y ☐N Do you wish to designate this person as a caregiver who will receive medical information related to your discharge planning? ☐Y ☐N	Relationship to Patient	Next of Kin Telephone Number(s)
Primary Care Physician's Name and Address:		Name of Pediatrician or Pediatric Group and address
Do you receive obstetrical care at one of these health centers? ☐ Adolescent Reproductive Health Services Clinic ☐ Dorchester House ☐ Southern Jamaica Plain Health Center ☐ Brookside Community Health Center ☐ Mattapan Community Health Center ☐ South End Community Health Center ☐ Codman Square Health Center ☐ Neponset Health Center ☐ Upham's Corner Health Center ☐ Whittier Street Health Center		Date Baby is Due

Please provide your insurance information below ***If you have no insurance coverage, or questions regarding your coverage, please call us at (617) 732-4087 for assistance.***

Name of Insurance:_____ Subscriber's Name:_____ Subscriber's Relationship to Patient:_____

Policy/Subscriber/ID #_____ Group Name:_____ Group Number:_____

Address of Insurance Company_____ Insurance Company Telephone:_____

Person responsible for financial arrangements if other than patient, spouse or significant other:

Last Name First Name Middle	Address	Phone #

Where did you receive your highest level of education so far? ☐ In the U.S. ☐ Not in the U.S. ☐ Declined (do not wish to provide)

Education Level Attained: ☐ 8th Grade or Less ☐ Declined ☐ Did not attend school ☐ Graduated-College ☐ Graduated-High School ☐ Graduated-Grad School
☐ Obtained GED ☐ Other ☐ Some College ☐ Some High School ☐ Some Technical Program ☐ Some Vocational Program ☐ Unavailable

Over→

Brigham and Women's Hospital, in partnership with the State of Massachusetts and the Boston Public Health Commission, is interested in learning more about differences in health. We want to make sure that all our patients get the best care possible, regardless of their race or ethnic background. We would like you to tell us your race or ethnicity so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. The collection of this information is confidential and voluntary. It will not affect the delivery of services nor ever be used to discriminate in the provision of services.

I. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACE? *You can choose more than one*

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined ☐ Native Hawaiian or other Pacific Islander ☐ Other: _____
☐ Unavailable ☐ White

II. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNICITY? *You can choose more than one*

☐ African American
☐ African-Ethiopian
☐ African-Ghanaian
☐ African-Liberian
☐ African-Nigerian
☐ African-Sierra Leonian
☐ African-Somalian
☐ American
☐ Asian Indian
☐ Asian-Bangladeshi
☐ Asian-Bhutanese
☐ Asian-Burmese
☐ Asian-Hmong
☐ Asian-Indonesian
☐ Asian-Iwo Jimian
☐ Asian-Madagascar
☐ Asian-Maldivian
☐ Asian-Nepalese
☐ Asian-Okinawan
☐ Asian-Pakistani
☐ Asian-Singaporean
☐ Asian-Sri Lankan
☐ Asian-Taiwanese
☐ Asian-Thai
☐ Brazilian
☐ Cambodian
☐ Cape Verdean
☐ Caribbean Island-Barbadian
☐ Caribbean Island-Dominica Islander
☐ Caribbean Island-Jamaican
☐ Caribbean Island-Tobagoan
☐ Caribbean Island-Trinidadian
☐ Caribbean Island-West Indian
☐ Caribbean Island-Belizean
☐ Caribbean Island-Costa Rican
☐ Central American-Indian
☐ Central American-Nicaraguan
☐ Central American-Panamanian
☐ Chinese
☐ Colombian
☐ Cuban
☐ Dominican
☐ Eastern European-Albanian
☐ Eastern European-Armenian
☐ Eastern European-Bosnian
☐ Eastern European-Croatian
☐ Eastern European-Polish
☐ Eastern European-Ukranian
☐ European-Belgian
☐ European-Czech
☐ European-Danish
☐ European-Dutch
☐ European-English
☐ European-Finnish
☐ European-French
☐ European-German
☐ European-Greek
☐ European-Icelandic
☐ European-Irish
☐ European-Italian
☐ European-Norwegian
☐ European-Scottish
☐ European-Spanish
☐ European-Swedish
☐ European-Swiss
☐ Filipino
☐ Guatemalan
☐ Haitian
☐ Honduran
☐ Japanese
☐ Korean
☐ Laotian
☐ Mexican, Mexican American, Chicano
☐ Middle Eastern-Afghanistani
☐ Middle Eastern-Assyrian
☐ Middle Eastern-Bahraini
☐ Middle Eastern-Egyptian
☐ Middle Eastern-Emirati
☐ Middle Eastern-Iranian
☐ Middle Eastern-Iraqi
☐ Middle Eastern-Qatari
☐ Middle Eastern-Saudi
☐ Middle Eastern-Syrian
☐ Portuguese
☐ Puerto Rican
☐ Russian
☐ Salvadoran
☐ South American-Argentinian
☐ South American-Bolivian
☐ South American-Chilean
☐ South American-Criollo
☐ South American-Ecuadorian
☐ South American-Guyanese
☐ South American-Indian
☐ South American-Paraguayan
☐ Middle Eastern-Israeli
☐ Middle Eastern-Jordanian
☐ Middle Eastern-Kuwaiti
☐ Middle Eastern-Lebanese
☐ Middle Eastern-Palestinian
☐ South American-Peruvian
☐ South American-Uruguayan
☐ South American-Venezuelan
☐ Unavailable
☐ Vietnamese

☐ Other: _____

☐ Declined (do not wish to provide)

III. ARE YOU OF HISPANIC OR LATINO ORIGIN?

IV. IN WHAT LANGUAGE DO YOU PREFER TO COMMUNICATE (SPEAK) DURING MEDICAL APPOINTMENTS OR TO DISCUSS HEALTH RELATED INFORMATION?

☐ African-Berber
☐ African-Dinka
☐ African-Efik
☐ African-Eritrean
☐ African-Ethiopian-Amharic
☐ African-Ethiopian-Tigrinya
☐ African-Fulah
☐ African-Hausa
☐ African-Igbo
☐ African-Kinyarwanda
☐ African-Kirundi
☐ African-Liberian
☐ African-Lingala
☐ African-Luganda
☐ African-Maay-Maay
☐ African-Mandingo
☐ African-Ndbele
☐ African-Nigerian
☐ African-Shona-Ndebele
☐ African-Somali
☐ African-Swahili-Kiswahili
☐ African-Twi
☐ African-Yoruba
☐ African-Zulu
☐ Akan
☐ Albanian
☐ Arabic
☐ Arabic-Moroccan
☐ Armenian
☐ Azerbaijani
☐ Belarusian
☐ Bengali
☐ Bosnian
☐ Bulgarian
☐ Burmese
☐ CART
☐ Catalan
☐ Chinese-Cantonese
☐ Chinese-Chaozhou
☐ Chinese-Fukienese
☐ Chinese-Fuzhou
☐ Chinese-Mandarin
☐ Chinese-Shanghainese
☐ Chinese-Toishanese
☐ Creole-Haitian
☐ Creole-Portuguese
☐ Croatian
☐ Czech
☐ Danish
☐ Dari
☐ Dutch
☐ English
☐ Filipino
☐ Finnish
☐ French
☐ Gaelic
☐ Georgian
☐ German
☐ Gujarati
☐ Hebrew
☐ Hindi
☐ Hmong
☐ Hungarian
☐ Icelandic
☐ Indonesian
☐ Italian
☐ Japanese
☐ Kannada
☐ Karen
☐ Kazakh
☐ Khmer
☐ Korean
☐ Kurdish
☐ Kyrgyz
☐ Laotian
☐ Latvian
☐ Lithuanian
☐ Macedonian
☐ Malay
☐ Maldivian
☐ Mongolian
☐ Nepali
☐ Norwegian
☐ Pashto
☐ Persian
☐ Polish
☐ Portuguese
☐ Portuguese-Brazilian
☐ Punjabi
☐ Romanian
☐ Russian
☐ Serbian
☐ Sign Language ASL
☐ Sign Language ASI-CDI
☐ Sign Language Other
☐ Slovak
☐ Slovenian
☐ Spanish
☐ Swedish
☐ Tagalog
☐ Tamil
☐ Teluga
☐ Thai
☐ Tibetan
☐ Turkish
☐ Ukrainian
☐ Urdu
☐ Uzbek
☐ Vietnamese
☐ Yiddish
☐ Other Language: _____

☐ Declined (do not wish to provide)

V. DO YOU PREFER TO HAVE WRITTEN MATERIALS IN THE SAME LANGUAGE IN WHICH YOU COMMUNICATE (SPEAK) DURING MEDICAL APPOINTMENTS OR TO DISCUSS HEALTH RELATED INFORMATION? ☐ Yes *☐ No

***IF YOU SELECTED NO, PLEASE INDICATE YOUR LANGUAGE PREFERENCE FOR WRITTEN MATERIALS:** _____