

Patient Registration

Patient Information

! Please let us know if you need assistance completing this form.

Patient First and Last Name: _____

Parent/Guardian Name (if under 18): _____

Preferred Name: _____

Pronouns:

- | | | | | |
|---------------------------------------|---|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> She/her/hers | <input type="checkbox"/> They/them/theirs | <input type="checkbox"/> Ey/em/eirs | <input type="checkbox"/> Ve/vir/vis | <input type="checkbox"/> Patient's name |
| <input type="checkbox"/> He/him/his | <input type="checkbox"/> Ze/hir/hirs | <input type="checkbox"/> Xe/xem/xyrs | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Choose not to disclose |

Date of Birth: _____ **Legal Sex:** Female Non-binary Don't know

SSN: _____ Male X Choose not to disclose

The following information will be saved in your electronic health record and helps our providers deliver personalized care. Please choose the option that best describes you. Currently our system allows only one selection.

- Gender Identity:**
- | | | | | | | |
|---------------------------------|---|---|---|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> Non-binary/genderqueer | <input type="checkbox"/> Transgender female | <input type="checkbox"/> Transgender male | <input type="checkbox"/> Two spirit | <input type="checkbox"/> Don't know | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Male | <input type="checkbox"/> Questioning | <input type="checkbox"/> Other _____ | | | | |

- Sex Assigned at Birth:**
- | | | | |
|---------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> Intersex | <input type="checkbox"/> Not recorded at birth certificate | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Male | <input type="checkbox"/> Don't know | | |

- Sexual Orientation:**
- | | | | |
|-----------------------------------|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Straight | <input type="checkbox"/> Lesbian | <input type="checkbox"/> Pansexual | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Asexual | <input type="checkbox"/> Queer | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Omnisexual | <input type="checkbox"/> Don't know | |

Home Address: _____

City, State, Zip: _____

- Permanent Temporary Confidential Choose not to disclose

Phone Number: (Cell) _____ **(Home):** _____ **(Work):** _____

Email Address: _____

- Relationship Status:**
- | | | | |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Married | <input type="checkbox"/> Widowed | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Domestic partner | <input type="checkbox"/> Significant other | <input type="checkbox"/> Don't know | |
| <input type="checkbox"/> Legally separated | <input type="checkbox"/> Single | <input type="checkbox"/> Other _____ | |

Race:

- | | | |
|---|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Japanese | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Korean | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> More than one race | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Pacific Islander | |

Ethnic Group:

- | | | |
|--|--|---|
| <input type="checkbox"/> Hispanic or Latino/a | <input type="checkbox"/> Mexican, Mexican American, or Chicano/a | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Not Hispanic or Latino/a | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Choose not to disclose |

Ethnic Background: _____

Additional Patient Information

Employment Status:

- | | | |
|---|---|---|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Active military duty | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Other |
| <input type="checkbox"/> Not Employed | <input type="checkbox"/> Self-employed | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Unemployed (retired) | <input type="checkbox"/> Student full-time | |
| <input type="checkbox"/> Unemployed due to disability | <input type="checkbox"/> Student part-time | |

Employer: _____

Occupation: _____

Preferred Language: _____

Need Intepreter:

- Yes No

**Preferred Method(s)
of Contact:**

- Mail
 Phone
 Email
 MyChart

Written Language: _____

Language Spoken: _____

Additional Demographics

Are you a veteran or do you have a military status?

Yes No

Emergency Contact Information

Name: _____ Relationship: _____

Cell phone: _____ Home phone: _____

Medical Insurance Information

Primary Insurance (if applicable):

Subscriber Name:

Secondary Insurance (if applicable):

Subscriber Name:

Patient Relationship
to Subscriber: _____

Subscriber

Date of Birth: _____

Subscriber Legal Sex:

Female Non-binary Don't know
 Male X

Patient Relationship
to Subscriber: _____

Subscriber

Date of Birth: _____

Subscriber Legal Sex:

Female Non-binary Don't know
 Male X

Dental Insurance Information

Primary Insurance (if applicable):

Subscriber Name:

Patient Relationship
to Subscriber: _____

Subscriber

Date of Birth: _____

Subscriber Legal Sex:

Female Non-binary Don't know
 Male X

By signing below, I acknowledge the information on this form is true and correct to the best of my knowledge. I acknowledge and give consent to receiving a survey related to my care via email and/or text.

Patient or Parent/Guardian Signature

Date

Patient Information

First and Last Name: _____ **Date of Birth:** _____

As a community health center, we are required to ask the following questions during each visit. This information is needed to receive additional funding and to better serve you and all members of our community.

1.

CHECK BOX	HOUSING SITUATION
<input type="checkbox"/>	I rent or own my home. I live with my parents/legal guardian. I live in a home with roommates; we all share the rent. I live in a college/university dorm.
<input type="checkbox"/>	I temporarily live with someone else (ex. couch-surfing).
<input type="checkbox"/>	I stay in a shelter, which provides meals and a place to sleep; I cannot stay there long (ex. homeless shelter).
<input type="checkbox"/>	I live in temporary housing to help me find my own home. I can stay here for up to two years (ex. drug treatment housing).
<input type="checkbox"/>	I live in a residence paid by rental assistance/Section 8 (public housing).
<input type="checkbox"/>	I currently reside in the street, my car, or encampment.
<input type="checkbox"/>	I experienced homelessness in the past year and my housing situation is none of the above choices.
<input type="checkbox"/>	I currently have a home but cannot afford to pay the rent or mortgage and/or I was told I will be evicted soon.
<input type="checkbox"/>	I currently live in a hotel.

2. How many people currently live in your household? _____

3. What is the combined monthly income of everyone in your household?

- Under \$500/month
 \$501 - \$1,000/month
 \$1,001 - \$2,500/month
 \$2,501 - \$4,000/month
 \$4,001 - \$5,500/month
 \$5,501 - \$7,000/month
 \$7,001 - \$8,500/month
 \$8,501+/month

4. Are you a migrant or seasonal worker?

- Migrant
 Seasonal
 Neither