PATIENT REGISTRATION FORM

SECTION I

FIRST NAME: ________________________ MIDDLE INITIAL: ________ LAST NAME: ______________________________

DATE OF BIRTH: _____/ _____/ _____ SOCIAL SECURITY NUMBER: ______-______-______

MAILING ADDRESS: _______________________________CITY: _____________________STATE: _______ZIP: ___________

HOME PHONE: (________) ______-__________ CELL PHONE: (________) ________-___________

PREFERRED METHOD OF CONTACT (CHECK ONE): ☐PHONE CALL ☐TEXT MESSAGE **PREFERRED PHONE:** ☐Home ☐Cell

PRIMARY LANGUAGE (CHECK ONE): ☐ENGLISH ☐SPANISH ☐OTHER: ____________________ **DO YOU NEED A TRANSLATOR?** ☐YES ☐NO

EMAIL (IF YOU WOULD LIKE PATIENT PORTAL): ____

GENDER AT BIRTH (CHECK ONE): ☐FEMALE ☐MALE

GENDER IDENITY TODAY (CHECK ONE): ☐FEMALE ☐MALE ☐ OTHER ☐TRANSGENDER MALE/FEMALE-TO-MALE ☐TRANSGENDER FEMALE/MALE-TO-FEMALE

MARITAL STATUS (CHECK ONE): ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐LEGALLY SEPARATED

SEXUAL ORIENTATION (CHECK ONE): ☐STRAIGHT ☐LESBIAN/GAY ☐BISEXUAL ☐SOMETHING ELSE ☐DON'T KNOW ☐WILL NOT DISCLOSE

RACE (CHECK ALL THAT APPLY): ☐ASIAN INDIAN ☐CHINESE ☐FILIPINO ☐JAPANESE ☐KOREAN ☐VIETNAMESE ☐OTHER ASIAN

☐NATIVE HAWAIIAN ☐OTHER PACIFIC ISLANDER ☐GUAMANIAN/CHAMORRO ☐SAMOAN

☐BLACK/AFRICAN AMERICAN ☐AMERICAN INDIAN/ALASKA NATIVE ☐WHITE/CAUCASIAN ☐ WILL NOT DISCLOSE

ETHNICITY (CIRCLE ONE): ☐WILL NOT DISCLOSE ☐NON-LATINO/NON-HISPANIC

☐MEXICAN/MEXICAN AMERICAN, CHICANO/A ☐PUERTO RICAN ☐CUBAN ☐ANOTHER HISPANIC, LATINO/A OR SPANISH ORIGIN

ARE YOU A MILITARY VETERAN? YES or NO

EMPLOYMENT STATUS (CHECK ONE): ☐STUDENT ☐UNEMPLOYED ☐ RETIRED ☐ACTIVE MILITARY DUTY ☐EMPLOYED

IF EMPLOYED, NAME OF EMPLOYER: ____

PRIMARY PHARMACY NAME: ______________________ **PHARMACY ADDRESS:** _________________________________

PHARMACY PHONE NUMBER: (________) ________-___________

SECTION II

FAMILY INCOME

Because we are partially funded by a federal grant, we are asked to collect income information. Please determine the number of persons in your household and check your annual (yearly) income range. This information is for generalized reporting regarding the health center, **NO PERSONAL INFORMATION IS SHARED**.

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: _______

Range 1	Range 2	Range 1	Range 1	Range 1	Range 1
( ) $0 to 20, 000	( ) $20, 001 to $40,000	( ) $40, 001 to $60,000	( ) $60, 001 to $80,000	( ) $80,001 to $100,000	( ) $100,001+

SECTION III - **LEGAL GUARDIAN INFORMATION MUST BE COMPLETED IF PATIENT IS UNDER 18 YEARS OF AGE**

RELATIONSHIP TO PATIENT: ____

FIRST NAME: ____________________ MIDDLE INITIAL: ________ LAST NAME: ___________________________

DATE OF BIRTH: _____/ _____/ _____ SOCIAL SECURITY NUMBER: ______-______-______

MAILING ADDRESS: ____

HOME PHONE: (________) ________-___________ CELL PHONE: (________) ________-________

SECTION IV- EMERGENCY CONTACT

FIRST NAME: ____________________ MIDDLE INITIAL: ________ LAST NAME: ___________________________

RELATIONSHIP TO PATIENT: _______________________________ DATE OF BIRTH: _____/ _____/ _____

MAILING ADDRESS: ____

HOME PHONE: (________) ________-___________ CELL PHONE: (________) ________-___________

SECTION V - PATIENT INSURANCE INFORMATION

PLAN I - PRIMARY

INSURANCE COMPANY: ____ MEMBER ID: ________________________

GROUP #: ______________________________ COPAY: $________

SUBSCRIBER INFORMATION FOR THIS INSURANCE PLAN

☐ **USE PATIENT**
NO NEED TO COMPLETE THE REST OF THIS PLAN

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ___________________________

SUBSCRIBER NAME: ____________________________________ **DATE OF BIRTH:** _____/ _____/ _____

SUBSCRIBER ADDRESS: ____

PLAN II - SECONDARY

INSURANCE COMPANY: ____ MEMBER ID: _________________________

GROUP #: ______________________________ COPAY: $________

SUBSCRIBER INFORMATION FOR THIS INSURANCE PLAN

☐ **USE PATIENT**
NO NEED TO COMPLETE THE REST OF THIS PLAN

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ___________________________

SUBSCRIBER NAME: ____________________________________ **DATE OF BIRTH:** _____/ _____/ _____

SUBSCRIBER ADDRESS: ____

PATIENT/GUARDIAN SIGNATURE: _______________________________________ DATE: ____________________

FOR OFFICE USE ONLY -REVIEWER INITIALS: ________