Community Health Centers

Patient Registration Form

Patient Information

Last Name	First Name	Middle	DOB	SSN#
			/ /	

Home Phone	Cell Phone	Work Phone	Primary Contact:	Ok to leave message?	Best time to reach you:	Preferred Language:
			☐ Home ☐ Cell ☐ Work	☐ Yes ☐ No	☐ AM ☐ PM	
Email Address				Ok to text message? ☐ Yes ☐ No		Interpreter Needed? ☐ Yes ☐ No

Mailing Address	Apt#	City	State	Zip Code	County
Home Address (If Different from Mailing)	Apt#	City	State	Zip Code	County

Emergency Contact

Emergency Contact Full Name	Relationship to Patient	Phone Number
Emergency Contact Address:		

We are requesting the following information of all patients in order to understand our patient needs better, to help our staff use the most respectful language when addressing you and for funding purposes that may help reduce the cost of your healthcare.

Gender at Birth:
☐ Female ☐ Male

Preferred Gender:

Gender Identity:
☐ Male
☐ Female
☐ Female-to-Male/Transgender
☐ Male-to-Female/Transgender
☐ Genderqueer, neither exclusively male nor female
☐ Choose not to disclose

Preferred Pronouns:
☐ He/him/his/his/himself
☐ She/her/hers/herself
☐ They/them/theirs/themselves
☐ Ze/zir/zir/zirs
☐ Xie/hir ("here")/hir/hirs/
☐ Co/co/cos/cos/cos
☐ En/en/ens/ens/enself
☐ Ey/em/eir/eirs/emself
☐ Yo/yo/yos/yos/yoself
☐ Ve/vis/ver/ver/verself

Sexual Orientation:
☐ Straight/ Heterosexual
☐ Lesbian/Gay/Homosexual
☐ Bisexual
☐ Do Not Know
☐ Choose not to disclose
☐ Something else, please describe: _____

Marital Status:
☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Separated ☐ Partner

Housing Status:
☐ Own-Private ☐ Rent-Private
☐ Rent–Public Housing (Section 8) ☐ Homeless Shelter
☐ Senior Housing ☐ Street
☐ Transitional ☐ Doubling Up
☐ Other: _____

Are you a:

Veteran	☐ Yes	☐ No
Seasonal Worker	☐ Yes	☐ No
Migrant Worker	☐ Yes	☐ No

Student:
☐ Full-Time
☐ Part-Time
☐ Not a student

Employment Status:
☐ Full-Time
☐ Part-Time
☐ Retired
☐ Active Military
☐ Reserved Military
☐ Self-Employed
☐ Not Employed

Employer Name: _____

Employer Address: _____

_____

_____

Employer Phone #: (____) ____-____

Race - Check all that apply
☐ White
☐ Black/African American
☐ Native American
☐ American Indian/Alaskan Native
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Samoan
☐ Other: _____
☐ Decline to specify

Ethnicity - Check one
☐ Mexican
☐ Mexican-American
☐ Chicano
☐ Puerto Rican
☐ Cuban
☐ Non-Hispanic
☐ Other: _____
☐ Decline to specify

Parent/Guardian Information – Please complete if patient is under 18 years of Age					Responsible Party
Mother's Name	DOB / /	Phone	Address	SSN#	☐
Father's Name	DOB / /	Phone	Address	SSN#	☐
Guardian's Name	DOB / /	Phone	Address	SSN#	☐

Insurance Information:			
Primary Insurance Name		Policy #	Group #
Name of the Insured	☐ Same as Patient	DOB of Insurance Holder:	SSN# of Insurance Holder:
Patient's Relationship to the Insured ☐Self ☐Spouse ☐ Child ☐ Other:		Address and Phone # of Insurance Holder:	
Secondary Insurance Name:		Policy #	

Pharmacy Information		
Pharmacy Name	Phone	City & State or Full Address if out of State

Primary Care Provider		
PCP Name	Phone	Address
Do you have an Advanced Directive: ☐ **Yes** ☐ **No**		**Do you have a Living Will:** ☐ **Yes** ☐ **No**

Other Healthcare Providers:		
Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty

I agree to allow Community Health Center to contact me regarding my private health information and treatment.

_____ _____

Signature of Patient or Representative Date

I verify that the information above is correct to the best of my knowledge. I hereby authorize my insurance to be billed by Community Health Center and acknowledge that I am financially responsible for unpaid balances.

_____ _____

Signature of Patient or Representative Date