COMMUNITY Medical Centers

PATIENT REGISTRATION

PLACE LABEL HERE

I. PATIENT INFORMATION

Patient Name: _____ _____ _____
(Must match name on MediCal &/or ID card) Last Name First Name Middle Name

☐ Previous ☐ Preferred Name: _____ Date of Birth: ____ / ____ / ____
Month Day Year

SSN: _____

Birth Sex: ☐ Male ☐ Female

Home Address: _____ Apt. _____ City _____ State _____ Zip _____

Mailing Address: _____ Apt. _____ City _____ State _____ Zip _____

Primary Phone: _____ Is this a cell phone? ☐ Yes ☐ No
Can we leave Voice Messages/Texts? ☐ Yes ☐ No

Secondary Phone: _____ Is this a cell phone? ☐ Yes ☐ No
Can we leave Voice Messages/Texts? ☐ Yes ☐ No

Email Address: _____

When you share your demographic information with us it is kept confidential. It will help us provide you with the best care possible and allows us to maintain funding to provide essential health care services.

1. **Current Gender:** ☐ Female ☐ Male ☐ Undifferentiated

2. **How do you identify yourself? (Check one)**
   ☐ Male ☐ Transgender Male/Female-to-Male (FTM)/Trans Man
   ☐ Female ☐ Transgender Female/Male-to-Female (MTF)/Trans Woman
   ☐ Genderqueer, neither exclusively male nor female
   ☐ Additional Gender Category, please specify: _____
   ☐ Choose not to Disclose

3. **Do you think of yourself as: (Check one)** ☐ Straight or Heterosexual ☐ Bisexual
   ☐ Lesbian, Gay, or Homosexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

4. **Preferred Pronouns:** ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs ☐ Ze, Hir
   ☐ Other ☐ Unknown ☐ Decline to State

5. **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated

6. **a) Student Status**
   ☐ Not a Student
   ☐ Part Time Student
   ☐ Full Time Student

   b) Student at:
   ☐ College/University _____
   ☐ Unified School District _____
   ☐ Other (please specify) _____

7. **Heritage**
   ☐ Arab/Middle Eastern
   ☐ Black/African American
   ☐ Native American/Alaskan
   ☐ White
   ☐ Native Hawaiian
   ☐ Other Pacific Islander
   ☐ Guamanian or Chamorro
   ☐ Samoan
   ☐ Chinese
   ☐ Filipino
   ☐ Indian
   ☐ Japanese
   ☐ Korean
   ☐ Vietnamese
   ☐ Other Asian
   ☐ Choose Not to Disclose

8. **Hispanic, Latino/a, Spanish Origin**
   ☐ Hispanic, Latino/a, Spanish Origin
   ☐ Cuban
   ☐ Mexican, Mexican American, Chicano/a
   ☐ Puerto Rican
   ☐ Another Hispanic, Latino/a, or Spanish Origin
   ☐ Hispanic, Latino/a, Spanish Origin, Combined
   ☐ Not Hispanic, Latino/a, Spanish Origin
   ☐ Choose Not to Disclose

9. **Preferred Language:** ☐ English ☐ Spanish ☐ Punjabi ☐ Urdu ☐ Tagalog ☐ ASL ☐ Other: _____

10. **Do you have difficulty receiving our services in English?** ☐ Yes ☐ No

11. **Is your current living situation stable?** ☐ Yes ☐ No
    Describe your current living situation: ☐ Home/Apartment ☐ Shelter ☐ Street/Camp ☐ Transitional
    ☐ Doubling Up (*living with friends or family*) Other: _____

12. In the last 2 years have you or an immediate family member (Check all that apply):

☐ Worked in any type of agriculture (farm work) – like planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, working with animals like cows, chickens, etc.?

☐ Lived away from home in order to work in any type of agriculture (farm work)?

13. Did you or an immediate family member stop migrating to work in agriculture (farm work) because of a disability or age (too old to work)? ☐ Yes ☐ No

14. Are you living in public housing? *(Section 8 is not considered Public Housing)* ☐ Yes ☐ No

If yes, please give name of agency/development: _____

15. Have you ever served in any branch of the armed services for any period of time, including the reserves?

☐ Army, Navy, Marines, Air Force, Coast Guard ☐ Not a Veteran

II. FOR MINORS (17 & UNDER) OR DEPENDENT ADULTS ONLY

Parent/Legal Guardian of Patient: _____ Date of Birth: ____/____/____

Relationship to Patient: _____

Parent/Legal Guardian of Patient: _____ Date of Birth: ____/____/____

Relationship to Patient: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

III. FINANCIAL INFORMATION

Do you currently have health insurance? ☐ Yes ☐ No

If yes, Name of Insurance: _____ Insurance #: _____

Family Size: _____ Family Income: _____ Monthly _____ Annually _____

RESPONSIBLE PARTY (Guarantor) ☐ Contact information same as section II. For Minors

(Statements/bills will be addressed to responsible party, if not covered by health insurance.)

Name: _____ Date of Birth: ____/____/____

Email: _____

Mailing Address: _____ Apt. _____ City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Work Phone: _____

IV. SHARING INFORMATION – FOR PATIENT USE ONLY

Please use this space to tell us who we are allowed to share, or release, information with. We use these instructions to share on your behalf. Please leave this section BLANK if you do not want your information shared with ANYONE.

Agency/Person: _____ Relationship: _____

Address: _____ Apt. _____ City _____ State _____ Zip _____

Telephone: _____

This person may ☐ Share any and all of my medical information. ☐ Receive my test results.

☐ Pick up my prescription medications in my absence. ☐ Schedule, Re-Schedule, or Cancel my appointments.

☐ Send messages to my care team.

This consent for disclosure will expire on _____, or 12 months after the signature date.

Print Name _____ Signature of Patient/Legal Guardian _____ Date _____

FOR OFFICE USE ONLY ☐ Telehealth Visit

Doubling Up/CareLink Eligibility: Yes ☐ No ☐ Data entered by: _____ Initials: _____ Date: _____