New Patient Registration Form

Name (first, last, middle initial): ________________ Maiden/Other Name: ________________

Physical Address: ________________ City: ________ State: ______ Zip: ______

Mailing Address (if different): ________________ City: ________ State: ______ Zip: ______

Home Phone: ____________ Mobile: ____________ Work: ____________ Ext: ______

Email: ________________________ DOB: ______ SSN: ____________

Sex: ☐ Male ☐ Female

Sex Assigned at Birth: ☐ Male ☐ Female

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other

Preferred Pronoun: ☐ He ☐ She ☐ They ☐ We ☐ Other

Race: (Check all that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Language: ________________ Do you need interpreter services? ☐ Yes ☐ No

Primary Pharmacy: ________________ Secondary Pharmacy: ________________

Insurance Information: *Please complete the following Insurance information and provide a copy of insurance card(s)*

Primary Medical ☐ Same as patient

Ins Company: ________________

ID #: ____________ Grp #: ________

Policy Holder Name: ________________

DOB: ________ SSN: ____________

Primary Dental ☐ Same as patient

Ins Company: ________________

ID #: ____________ Grp #: ________

Policy Holder Name: ________________

DOB: ________ SSN: ____________

Secondary Medical ☐ Same as patient

Ins Company: ________________

ID #: ____________ Grp #: ________

Policy Holder Name: ________________

DOB: ________ SSN: ____________

Secondary Dental ☐ Same as patient

Ins Company: ________________

ID #: ____________ Grp #: ________

Policy Holder Name: ________________

DOB: ________ SSN: ____________

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☐ I have more than two medical insurance carrier

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Marital Status: ☐ Annulled ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Never Married ☐ Widowed ☐ None

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired - Retirement Date: ________ ☐ Self Employed ☐ Active Military ☐ Student ☐ Not Employed

Population Characteristics:

- ☐ I am a migrant dairy worker
- ☐ I am a seasonal migrant worker (non-dairy)
- ☐ I currently rent or own my home (or live with parent/guardian)
- ☐ I currently live in a shelter
- ☐ I currently live in transitional housing
- ☐ I rely on relatives/friends for housing
- ☐ I currently live on the street
- ☐ I live in a hotel or camper
- ☐ I am a US veteran

Person financially responsible, if not the patient – e.g. Parent of a minor child:

Name: ________________________________ Address: ____

Phone: __________________________Home/Work: _____________________DOB: __________________________

Name of Person Completing This form (if other than patient): ____

☐ Check here if the person completing this form has legal authority to consent for treatment of the registrant (requires supporting documentation if other than parent of a minor)

Income Information: *Please circle the appropriate family size and corresponding household income range. All answers are confidential.*

Family Size	0-100%	101-150%	151-200%	Over 200%
	Household Income Range Based on Family Size			
1	$0 to $12,490	$12,491 to $18,735	$18,736 to $24,980	$24,981 & Over
2	$0 to $16,460	$16,461 to $24,690	$24,691 to $32,920	$32,921 & Over
3	$0 to $21,330	$21,331 to $31,995	$31,996 to $42,660	$42,661 & Over
4	$0 to $25,750	$25,751 to $38,625	$38,626 to $51,500	$51,501 & Over
5	$0 to $30,170	$30,171 to $45,255	$45,256 to $60,340	$60,341 & Over
6	$0 to $34,590	$34,591 to $51,885	$51,886 to $69,180	$69,181 & Over
7	$0 to $39,010	$39,011 to $85,515	$85,516 to $78,020	$78,021 & Over
8	$0 to $43,430	$43,431 to $65,145	$65,146 to $86,860	$86,861 & Over