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 ☐ Bisexual ☐ Don't Know ☐ Lesbian, Gay, or Homosexual ☐ Something Else

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

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

Race: (Check all that apply) ☐ White ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ American Indian / Alaska Native ☐ 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 $12,880	$12,881 to $19,320	$19,321 to $25,760	$25,761 & Over
2	$0 to $17,420	$17,421 to $26,130	$26,131 to $34,840	$34,841 & Over
3	$0 to $21,960	$21,961 to $32,940	$32,941 to $43,920	$43,921 & Over
4	$0 to $26,500	$26,501 to $39,750	$39,751 to $53,000	$53,001 & Over
5	$0 to $31,040	$31,041 to $46,560	$46,561 to $62,080	$62,081 & Over
6	$0 to $35,580	$35,581 to $ 53,370	$53,371 to $71,160	$71,161 & Over

7+ Add additional $4,540 to each category