COMMUNITY Medical Centers

Patient Registration

PLACE LABEL HERE

PATIENT INFORMATION

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

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

Birth Sex: ☐ Male ☐ Female

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

Home Address: ________________________ **Apt.** ____ **City** __________ **State** _____ **Zip** ________

Mailing Address: ______________________ **Apt.** ____ **City** __________ **State** _____ **Zip** ________

Home Phone: __________________ **Cell:** _________________ **Work Phone:** __________________

Best Phone Number for Contact: ☐ Home ☐ Cell ☐ Work ☐ Do not Call

Would you like to receive Voice Messages/Voicemails? ☐ Yes ☐ No, Do Not Leave Voice Messages

Would you like to receive Text Messages? ☐ Yes ☐ No, Do Not Leave Text Messages

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. Race/Ethnicity
(Check ALL that apply)

- ☐ African American/Black
- ☐ American Indian/Alaskan Native
- ☐ Asian Chinese
- ☐ Asian Indian
- ☐ Southeast Asian
- ☐ Other Asian
- ☐ Hispanic/Latino Black
- ☐ Hispanic/Latino More Than One Race
- ☐ Hispanic/Latino Unavailable/Unknown
- ☐ Hispanic/Latino White
- ☐ Middle Eastern/North African
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White/Caucasian
- ☐ Unavailable/Unknown

2. Preferred Language:

- ☐ English ☐ Urdu
- ☐ Spanish ☐ Tagalog
- ☐ Punjabi ☐ ASL
- ☐ Other: ____________

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

4. Marital Status

- ☐ Single ☐ Married
- ☐ Divorced ☐ Widowed
- ☐ Life Partner
- ☐ Legally Separated

5. a)Student Status

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

5. b)Student at:

- ☐ ________________ Unified School District
- ☐ ________________ College/University
- ☐ Other (please specify)____________

6. 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

7. Current Gender

- ☐ Female
- ☐ Male
- ☐ Undifferentiated

8. 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

9. How do you identify yourself? (Check one)

- ☐ Male ☐ Female
- ☐ Transgender Male/Female-to-Male (FTM)/Trans Man
- ☐ Transgender Female/Male-to-Female (MTF)/Trans Woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional Gender Category, please specify:__________
- ☐ Choose not to Disclose

10. 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: ___________________________

(Please fill out a Care Link Eligibility Form if "No" or any box is checked in the box above)

11. Are you living in public housing? (*Section 8 is not considered Public Housing*) ☐ Yes ☐ No
If yes, please give name of agency/development: ___________________________

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

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)
(*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 Code**______
Home Phone: ___________________ **Cell:** ___________________ **Work Phone:** ___________________

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: ___________________________

SHARING INFORMATION

Please use this space to tell us who we are allowed to share, or release, information with.

Please leave this section BLANK if you do not want your information shared with ANYONE.

Person #1: ___________________________

Relationship: ___________________________

This person may:

☐ Share any and all of my medical information.
☐ Pick up my prescription medications in my absence.
☐ Send messages to my care team.
☐ Receive my test results.
☐ Schedule, Re-Schedule, or Cancel my appointments.

Person #2: ___________________________

Relationship: ___________________________

This person may:

☐ Share any and all of my medical information.
☐ Pick up my prescription medications in my absence.
☐ Send messages to my care team.
☐ Receive my test results.
☐ Schedule, Re-Schedule, or Cancel my appointments.

___________________	___________________	___________________
Print Name	**Signature of Patient/Legal Guardian**	**Date**

FOR OFFICE USE ONLY
Home Clinic: ___________________ **Data entered by:** _____________ **Initials:** _____________ **Date:** _____________