COMMUNITY Medical Centers

PATIENT REGISTRATION

PLACE LABEL HERE

I. PATIENT INFORMATION

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

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

SSN: _____ Sex: ☐ Male ☐ Female ☐ Nonbinary

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

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

Mobile Phone: _____ Can we leave Voice Messages/Texts? ☐ Yes ☐ No

Alternate Phone: _____ Can we leave Voice Messages/Texts? ☐ Yes ☐ No

☐ Mobile ☐ Home ☐ Work ☐ Other

Email Address: _____

You may contact me using: ☐ MyChart ☐ Text ☐ Phone ☐ Mail ☐ Email

When you share your demographic information with us it is kept confidential. It will help us provide you with the best care possible.

1. **Where are you currently living?** ☐ Home/Apartment ☐ Temporarily living with others ☐ Outside (Street/Car) ☐ Shelter ☐ Transitional Housing ☐ Other: _____

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

3. **In the last 2 years have you or an immediate family member (Check all that apply):**
   ☐ (Seasonal) 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.?
   ☐ (Migrant) Lived away from home in order to work in any type of agriculture (farm work)?
   ☐ (Migrant) 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)?
   ☐ No, neither.

4. **What sex were you assigned at birth:** ☐ Female ☐ Male ☐ Intersex

5. **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
   ☐ Nonbinary ☐ Other ☐ Questioning ☐ Two Spirit
   ☐ Additional Gender Category, please specify: _____
   ☐ Choose not to Disclose

6. **Do you think of yourself as: (Check one)** ☐ Straight ☐ Gay ☐ Bisexual ☐ Lesbian ☐ Queer ☐ Pansexual ☐ Asexual ☐ Omnisexual ☐ Something Else _____
   ☐ Choose Not to Disclose ☐ Don't Know

7. **Preferred Pronouns:** ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs ☐ Ze, Hir, Hirs ☐ Ey, Em, Ei ☐ Xe, Xem, Xyrs ☐ Ve, Vir, Vis ☐ Other ☐ Patient's Name ☐ Decline to State ☐ Unknown

8. **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Domestic Partner ☐ Significant Other ☐ Other ☐ Unknown

9. Hispanic, Latino/a/x, or Spanish Origin:

☐ Hispanic, Latino/a/x, or Spanish Origin
- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a/x, or Spanish Origin

☐ Not Hispanic, Latino/a/x, or Spanish Origin

☐ Unknown/Choose Not to Disclose

10. Race/Ethnicity (Check all that apply):

- ☐ Arab
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian Indian
- ☐ Black/African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Unknown/Choose Not to Disclose

11. Emergency Contact:

First Name: _____ Last Name: _____

Relationship: _____ Phone: _____

12. a) Student Status

☐ Student Full Time

☐ Student Part Time

b) Student at:

☐ School/College/University _____

☐ Elementary/High School _____

☐ Other (please specify) _____

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

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

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

☐ Active Duty ☐ Inactive Duty ☐ No Previous Experience ☐ Reservist ☐ Veteran

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

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

Name: _____ Relationship to Patient: _____

Date of Birth: ____/____/____ SSN: _____ Sex: ☐ Female ☐ Male ☐ Nonbinary

☐ Check if the address is the same as the patient's.

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

Mobile Phone: _____ Alternate Phone: _____

☐ Mobile ☐ Home ☐ Work ☐ Other

Other Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Date of Birth: ____/____/____ SSN: _____ Sex: ☐ Female ☐ Male ☐ Nonbinary

☐ Check if the address is the same as the patient's.

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

Mobile Phone: _____ Alternate Phone: _____

☐ Mobile ☐ Home ☐ Work ☐ Other

III. FINANCIAL INFORMATION

Do you currently have health insurance? ☐ Yes ☐ No

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

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

FOR OFFICE USE ONLY ☐ Telehealth Visit

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