



PATIENT REGISTRATION FORM

A **PATIENT INFORMATION** (Please print)

Name: Last		First	Middle
Address: Street		City	State Zip Code
Date of Birth: / /		Social Security #	Birthplace: City State/Country
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single w/partner <input type="checkbox"/> Single w/o partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Telephone #: [Okay to call? Y or N] () -	Home: () -	Work: () -	Pager/ Cell Phone: () -
Fluent in English? <input type="checkbox"/> Yes <input type="checkbox"/> No Preferred language: _____ Years of education completed: ____			
Interpretive Service Needs: Interpreter Services Required: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mother's Maiden Name:		Name of Employer:	Driver's License Number:

B **RESPONSIBLE PARTY** (Parent, Guardian, Authorized Representative)

Name: Last		First	Middle	Relationship to child:
Address: Street		City	State	Zip Code
Birth date: / /		Social Security #	Birthplace: City State/Country	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single w/partner <input type="checkbox"/> Single w/o partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Telephone #: [Okay to call? Y or N] () -	Home: () -	Work: () -	Cell Phone: () -	
Fluent in English? <input type="checkbox"/> Yes <input type="checkbox"/> No Preferred language: _____ Years of education completed: ____				
Interpretive Service Needs: Interpreter Services Required: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Mother's Maiden Name:		Name of Employer:	Driver's License Number:	

Date: _____

Chart #: _____

MUST COMPLETE REVERSE SIDE



Patient's Ethnicity:

African-American/Black

African: East West North South Central

Central-American/Country: _____.

Asian/Pacific Islander (API):

Asian Indian Chinese Filipino Japanese Korean Thai Tongan

Vietnamese Other API: _____

Latino:

Mexican-American Central-American/Country: _____.

South American/Country: _____.

Caucasian Native American Undeclared Other: _____

Emergency Contact: (not your own phone number)

Name: Last	First	Home:
		() -

Health Coverage:

Medi-Cal Medicare Private Ins.: _____ Sliding Scale Other: _____

Referral Source:

Friend/Family Phone Book TV/ Radio Outreach Newspaper Other : _____.

C. OTHER INFORMATION

What is your present living situation (residence)

- Own a home
- Rent a home, apartment or room on monthly (or longer) basis
- Temporarily living with relative or friend
- Shelter (homeless shelter, transition house, rescue mission, etc.)
- Living outside/camping (including car or RV)
- Other transitional housing (such as Union Rescue Mission, L.A. Mission, Jenesse)
- Hotel or motel room
- Other (please explain) _____

Have you been homeless during the past twelve months? Yes No

Do you have an Advance Directive? Yes No If yes, please provide a copy.

If no, information given. _____ (Staff Initials)

I certify that all this information is correct to the best of my knowledge.

Signature

Date