Patient Registration Form

Please complete to the best of your knowledge. For areas that do not apply to the patient please enter "N/A".

Patient's Name *First* *MI* *Last*	**Date of Birth (DOB)** *MM/DD/YY* ☐ Under 18?
	Social Security Number

Mailing Address *Street and Apartment Number*	*City*	*State*	*Zip*	*County*
Physical Address ☐Same as Mailing *Street and Apartment Number*	*City*	*State*	*Zip*	*County*

1st Phone ☐ Cell ☐ Home ☐Work OK to Leave Message? ☐Yes ☐No	**2nd Phone** ☐ Cell ☐ Home ☐Work OK to Leave Message? ☐Yes ☐No
Email Address **OK to send secure Message? ☐Yes ☐No**	**Text Message (enter phone number)** **OK to send a text message? ☐Yes ☐No**

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Emergency Contact **Name**	**Relationship**	**Cell Phone** **Home Phone** **Work Phone**

Do you have Medical or Dental Insurance? Please present your insurance card to the Medical Receptionist.

☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐Other ______________________________

☐ No Insurance

Primary Medical Insurance Plan	**Insured Name/Policy Owner Name**	**Insured Date of Birth**	**Relationship to Patient**
Policy Number			
Secondary Medical Insurance Plan	**Insured Name/Policy Owner Name**	**Insured Date of Birth**	**Relationship to Patient**
Policy Number			
Dental Insurance Plan	**Insured Name/Policy Owner Name**	**Insured Date of Birth**	**Relationship to Patient**
Policy Number			

Parent or Guardian Name **First** **MI** **Last**

☐ **Same as Patient** **Parent or Guardian Date of Birth / /**

Parent/Guardian Address **Street**	**City**	**State**	**Zip Code**

Parent/Guardian Employer Name	**Parent/Guardian Work Phone**

How did you hear about us? ☐ Family/Friend ☐ Shelter ☐ Health Department ☐ Hospital ☐ Social Services ☐ Media ☐ Other ______________________________

Race (check all that apply)	**Ethnicity**	**Sexual Orientation**	**Gender Identity**
☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Declined to Answer	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined to Answer **Preferred Language** ☐ English ☐ Spanish ☐ Chinese ☐ Arabic ☐ Vietnamese ☐ Other ____________ **Are interpreter services needed?** ☐**Yes** ☐**No**	☐ Straight/not Lesbian or Gay ☐ Lesbian or Gay ☐ Bisexual ☐ Unknown ☐ Declined to Answer **What sex were you assigned at Birth?** ☐ Female ☐ Male ☐ Declined to Answer	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other ☐ Declined to Answer

Do you live in Public Housing? ☐Yes ☐No **Are you a Veteran?** ☐Yes ☐No

Homeless Status

☐ Not Homeless

☐ Street
(living outdoors, encampment, car, makeshift housing)

☐ Doubling Up
(person who is living with others; arrangement generally considered temporary and unstable)

☐ Shelter
(organized shelter)

☐ **Transitional Housing**
(transitioning from a homeless environment, do not include jail, institutional treatment programs, military, schools or other institutions)

☐**Yes** ☐ **No** **Migrant Farm Worker** – Individual who is required to be absent from a permanent place of residence for the purpose of seeking remunerated employment in agricultural work

☐ **Yes** ☐ **No** **Seasonal Farm Worker** – Individual who are employed in temporary farm work but do NOT move from their permanent residence to seek work; they may also have other sources of employment

Please circle the range below indicating your estimated annual household income according to the number of people living in your home. Advance Community Health is required to report this information to the Federal government, and it helps us to better understand the needs of the communities we serve. ***No identifying information shall be disclosed to the federal government. Your anonymity is protected.***

# of People in Household				
1	*$0 – $12,140*	*$12,141 - $18,210*	*$18,211 - $24,280*	*More than $24,280*
2	*$0 – $16,460*	*$16,461 - $24,690*	*$24,691 - $32,920*	*More than $32,920*
3	*$0 – $20,780*	*$20,781 - $31,170*	*$31,171 - $41,560*	*More than $41,560*
4	*$0 – $25,100*	*$25,101 - $37,650*	*$37,651 - $50,200*	*More than $50,200*
5	*$0 – $29,420*	*$29,421 - $44,130*	*$44,131 -$58,840*	*More than $58,840*
6	*$0 – $33,740*	*$33,741 - $50,610*	*$50,611 - $67,480*	*More than $67,480*

Please list your Pharmacy Information:

Pharmacy Name: ____

Pharmacy Address: ____

____

Pharmacy Telephone Number: ____

Would you like information on our Sliding Fee Discount Program? ☐ Yes ☐ No