

PATIENT REGISTRATION FORM

(Please print)

Date: _____

Chart #: _____

1. Patient's Name: _____ 2. Sex: Male Female
Last First Middle

3. Address: _____
Street City State Zip

4. Home Phone: () _____ 5. Cell/Alternate Phone () _____
 OK to call OK to call

6. Birth date: _____ 7. Social Security #: _____ - _____ - _____
Mo/Day/Yr

8. Mother's Maiden Name: _____ 9. E-mail address: _____

10. Marital Status: Single/Never married Married Separated Divorced Widowed

11. Are you transgender? No Yes If yes: Male to Female Female to Male

12. Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian Pacific Islander White

13. Ethnicity Armenian Guatemalan Mexican Sri Lankan
 Asian Indian Hmong Nepali Thai
 Bangladeshi Honduran Pakistani Tongan
 Cambodian Indonesian Pilipino Vietnamese
 Chinese Japanese Russian Other (pls. specify):
 Guamanian or Chamorro Korean Salvadorian Samoan _____
 Laotian

14. How did you hear about us? APHCV Staff Friend/Family Fair/Festival Radio T.V.
 Building sign Business/Agency: _____ Newspaper/Magazine: _____ Other: _____

15. Are you Hispanic / Latino? Yes No 16. Birthplace: _____

17. Year arrived in U.S.: _____ N/A 18. Highest education completed: Elementary Jr. High
 High School College Above college N/A

19. Citizenship: U.S. Permanent Resident Visitor Other: _____

20. Employment Status: Employed Unemployed Student (Full time Part time)

21. Preferred language with Clinician: _____ 22. Need an interpreter? Yes No
(If patient is a minor, indicate primary language of patient's legal guardian)

23. Are you: a Veteran? a Homeless? a Migrant Worker? a Disabled: _____

24. Occupation: _____ Business Food Service Health Care Homemaker
 Laborer Retail/Wholesale Self-employed Other: _____

25. Health Insurance coverage: None Medi-Cal/PE Medicare Private Insurance: _____

26. Spouse/parent(s)/significant others: _____
Relation to patient: _____ Phone # (If different than patient): () _____

27. Contact in case of emergency: _____
() _____

Name Relation Phone

Address City State Zip