ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

Patient Registration

Date: _____

Patient Last Name	**Patient First Name**	**Patient Middle Name**

Social Security #	**Date of Birth** (mm/dd/yyyy)	**Gender at birth:** □ Male □ Female

Current Gender: □ Male □ Female	**Are you transgender?** □ Yes □ No If Yes, select: □ Trans- Male to Female or □ Trans–Female to Male

Street Address			**Cell Phone**
City	**State**	**Zip**	**Home Phone**

What is your marital status? (check one) □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed	**Day Phone**
Student Status: (check one) □ Full time □ Part- time □ Not a student	**Preferred Phone Number:** □ Home □ Cell □ Day
Patient Email Address:	**Contact Preference:** □ No Preference □ Phone □ Email/Patient Portal □ Mail

Race: Please select all apply from the following race listing:
□ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian
□ Other Pacific Islander □ White □ More than one Race

Preferred language?	**Do you need an Interpreter?** □ Yes □ No

Birthplace:	**Ethnicity:**
□Bangladesh □Cambodia □China □El Salvador □Guatemala □Japan □Korea □Mexico □Philippines □Thailand □United States □Vietnam □ Other:_____	□Asian Indian □Bangladeshi □Cambodian □Central American □Chinese □Japanese □Korean □Mexican □Pilipino □South American □Thai □Vietnamese □White □Other:_____

Year Arrived in US: Please put N/A if you're born in U.S.	**Citizenship:** □ U.S. □Permanent Resident □Tourist □Other	**What is your highest Level of education completed?** (Check one) □ Elementary □ Junior High School □ High School □ College □ Graduate Degree or Higher □ N/A

Do you have a physical or mental disability that has prevented or will prevent you from working for more than a year? □ Yes □ No	**Is it okay to send mail to your address** □ Yes □ No
Emergency Contact Information **Last Name:** **First Name**	**Relationship to patient:** □Spouse □Friend □ Parent/Legal Guardian □Other

Emergency Contact Phone number: □ Home □ Work □ Cell

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Patient's Parent/Guarantor Information (Parent or Legal Guardian for Children Under 18 years)		
Parent 1 Information **Last Name:** **First Name:**	**Relationship to patient:** □ Parent □ Foster Parent □ Step parent □ Legal Guardian □Other	
Parent Address **City** **State** **Zip**		**Parent's Email address:**
Parent Phone Number	**Parent Date of Birth** (mm/dd/yyyy)	**Parent Gender** □ Male □ Female
If NO second Parent information: Please check the box □ (and skip to Patient Information)		
Parent 2 Information **Last Name:** **First Name:**	**Parent/Relationship to patient:** □ Parent □ Foster Parent □ Step parent □ Legal Guardian □Other	
Parent Address **City** **State** **Zip**		**Parent's Email address:**
Parent Phone Number	**Parent Date of Birth** (mm/dd/yyyy)	**Parent Gender** □ Male □ Female

Patient Information		
Birth Mother's Full Name (before marriage) Last (Maiden Name) First Name Middle Name		
Are you Homeless? □Yes □ No	**Are you a LAUSD student?** □Yes □ No	**Are you or your family members Agricultural Workers?** □Yes □ No
Are you Hispanic or Latino? □Yes □ No	**Are you a veteran of US Armed Forces?** □ Yes □ No	
How many people in your family? only include yourself, spouse and minor children under 18 years	**What is your household annual income?** Combined income of the persons listed in your family, if they are working	

How did you hear about our clinic? (Please circle all that apply)

APHCV Employee	Brochure/Flyer	Fair/Festival/Event	Internet-Google/Yahoo/Etc.
Search Ad-Billboard/Bus	Building Sign	Hospital/Doctor	Internet-Yelp/Health Grades
Ad-Newspaper/Magazine	Friend/ Family	Internet-APHCV website	Patient
Ad-TV/Radio	HMO/Insurance List	Internet-Advertisement	School

Name of the person who completed the form if it's different from patient: _____

Please turn in the completed forms to Front Office staff.
Thank you.