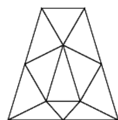


AllCare
HEALTH CENTER

PATIENT REGISTRATION FORM

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name:______________________ Last Name: ______________________

Preferred Name:______________________ Middle Initial: __________

Social Security Number (SSN):______________________ Date of Birth (mm/dd/yyyy): ______________________

Address:______________________ City:__________ State:______ Zip: __________

Preferred Language: ______________________ Interpreter Needed? ☐ Yes ☐ No

Please fill out any/all contact methods. Check box for preferred **contact method:**

☐ Preferred Phone:______________________ ☐ Cell ☐ Home ☐ Work ☐ Other

☐ Alt. Phone: ______________________ ☐ Cell ☐ Home ☐ Work ☐ Other

Email Address: ______________________

Please check which of the following best describes your **sex assigned at birth:**

☐ Male ☐ Female

Please check which of the following best describes your **gender identity:**

☐ Male ☐ Female ☐ Transgender male/female-to-male ☐ Transgender female/male-to-female

☐ Choose not to disclose ☐ Don't know/Not applicable ☐ Non-Binary

Please check which of the following best describes your **sexual orientation:**

☐ Straight/Heterosexual ☐ Lesbian, Gay or homosexual ☐ Bisexual

☐ Choose not to disclose ☐ Don't know/Not applicable ☐ Something Else

Please check which of the following best describes your **Preferred Pronouns:**

☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir

☐ Decline to answer ☐ Unknown ☐ Other: __________

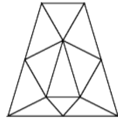
Please check which of the following best describes your **housing status:**

Are you homeless? ☐ Yes ☐ No

If yes, please describe your housing status:

☐ Homeless shelter ☐ Street homeless ☐ Transitional ☐ Permanent Supportive Housing

☐ Doubling Up ☐ Other homeless:______



AllCare
HEALTH CENTER

PATIENTREGISTRATION FORM

Please answer the following questions:

Are you a veteran? ☐ Yes ☐ No

Are you a migrant farm worker? ☐ Yes ☐ No ☐ Seasonal

Are you employed ☐ Yes ☐ No

If yes, Full-Time or Part-Time: ______________________________

Please check which of the following best describes **your race.** Please only select

☐ American Indian/Alaskan Native ☐ Chinese ☐ Japanese ☐ More than one Race ☐ Other Pacific Islander

☐ Asian Indian ☐ Filipino ☐ Korean ☐ Native Hawaiian ☐ Samoan ☐ White

☐ Black/African American ☐ Guamanian or Chamorro ☐ Other Asian ☐ Vietnamese ☐ Unreported/Unknown

Please check which of the following best describes **your ethnicity.** Please only select one:

☐ Mexican ☐ Cuban ☐ Another Hispanic, Latino/a, or Spanish origin ☐ Middle Eastern/North African

☐ Puerto Rican ☐ Chicano ☐ Non-Hispanic, Latino/a, or Spanish Origin ☐ Decline to report

Please check which of the following best describes your primary medical coverage type. Please select only one:

☐ Medicaid ☐ Medicare ☐ Private or commercial insurance (including through Marketplace) ☐ None or uninsured

SECTION II: PATIENT HOUSEHOLD INFORMATION

For our federal grant reporting, we are required to track income categories, but we do not include your personal information

Please provide your Household Family Size: ____________________

Please provide your Household Family Income:

Annual Income____________________

OR

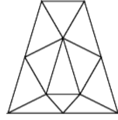
Monthly Income:________________________________

☐ I decline to disclose my income

SECTION III: INSURANCE INFORMATION

Insurance Name:____Policy number/Enrollment ID: ________________________________

Group ID:____Member ID: ____



PATIENT REGISTRATION FORM

SECTION IV: FINANCIAL RESPONSIBLE PARTY INFORMATION

☐ If the Financial Responsible Party is the same as the Patient Information, please check this box

First Name:______________ Last Name: ______________ Middle Initial:________

Preferred Name:______________________________

Social Security Number (SSN):______________________ Date of Birth (mm/dd/yyyy): ______________________

Address:________________________________ City:______________ State:________ Zip: ____________

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Preferred Phone:______________________________ ☐ Cell ☐ Home ☐ Work ☐ Other

☐ Alt. Phone: ______________________________ ☐ Cell ☐ Home ☐ Work ☐ Other

Email Address: ____

Preferred Language: ______________________________ Interpreter Needed? ☐ Yes ☐ No

SECTION V: SHARE OF INFORMATION

I, ______________________________, authorize All Care Health Center's medical and care coordination staff to discuss (share) health or medical information regarding my care with: ______________________________

Patient Signature: ______________________________ Today's Date: ______________________________

SECTION VI: EMERGENCY CONTACT INFORMATION

Emergency Contact: ____

Relationship to Patient:______________________ Phone Number: ______________________

How did you hear about All Care Health Center? ______________________________

I authorize release of information regarding continuation of care and / or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature:____ Date: ______________