

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PATIENT REGISTRATION FORM



### Patient Information

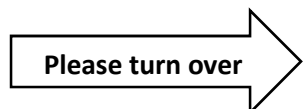
<b>Legal Name*</b>	Last	First	Middle Initial	<b>Preferred Name:</b>
<b>Previous Name</b>	Last	First	Middle Initial	
<b>Date of Birth</b>	Month Day Year / /		<b>Social Security #</b>	
<b>Home Phone</b> ( )			<b>Cell Phone</b> ( )	
<b>Mailing Address</b>	City		State	Zip
<b>Physical Address (if different from mailing)</b>	City		State	Zip
<b>Emergency Contact's Name</b>	Phone Number		Relationship to Patient	

### Responsible Party Information (For all patients under age 18)

<b>Name</b>	Phone Number	Relationship to Patient	Date of Birth / /
<b>Mailing Address</b>	City		State Zip

### Demographic Information

<b>1) Sex at birth</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>2) Current Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed	<b>3) Student Status</b> <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-time student <input type="checkbox"/> Not a student
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Staff Initials: \_\_\_\_\_

Revision: December 2017

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<b>4) Employment Status</b> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not-employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Reserved for National Assignment <b>Employer:</b> _____	<b>5) Pharmacy of Choice:</b> _____ Name _____ City/State _____	<b>6) Gross annual (before taxes) household income? (include spouse)</b> \$ _____ <input type="checkbox"/> No income <b>6a) How many people (including yourself) does your income support? (if you are pregnant count unborn baby(ies))</b> _____	
<b>7) Race (check all that apply)</b> <input type="checkbox"/> African American / Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Native American / Alaskan Native / Inuit <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other, Please Specify: _____	<b>8) Ethnicity</b> <input type="checkbox"/> Hispanic/Latino/Latina <input type="checkbox"/> Not Hispanic/Latino	<b>9) Migrant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>10) US Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>11) United States Citizen or Legal Immigrant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>12) Public Housing Resident?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>13) Homeless</b> <input type="checkbox"/> Not Homeless (has permanent established residence) <input type="checkbox"/> Primary Residence is Supervised Private or Public Facility <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Lives on Street <input type="checkbox"/> Lives in Car <input type="checkbox"/> Lives at a Shelter <input type="checkbox"/> Stays with Family/Friends <input type="checkbox"/> Other, Please Specify: _____	<b>14) Gender Identity</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender F→M <input type="checkbox"/> Transgender M→F <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose	<b>15) Sexual Orientation?</b> <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose	<b>16) Referral Source</b> <input type="checkbox"/> Self <input type="checkbox"/> Friend or Family Member <input type="checkbox"/> Health Provider <input type="checkbox"/> Emergency Room <input type="checkbox"/> Internet/newspaper/radio <input type="checkbox"/> Other _____

I hereby certify that all of the information given, including income, is correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month / Day / Year

\_\_\_\_\_  
Relationship to patient if not self

Staff Initials: \_\_\_\_\_

Revision: December 2017