

Patient Name: _____ Date of Birth: _____

PATIENT REGISTRATION FORM



Patient Information

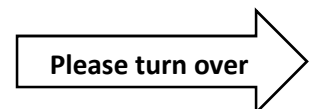
Legal Name*	Last	First	Middle Initial	Preferred Name:
Previous Name	Last	First	Middle Initial	
Date of Birth	Month Day Year / /		Social Security #	
Home Phone ()			Cell Phone ()	
Mailing Address			City	State Zip
Physical Address (if different from mailing)			City	State Zip
Emergency Contact's Name		Phone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

Responsible Party Information (For all patients under age 18)

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

Demographic Information

1) Sex at birth <input type="checkbox"/> Female <input type="checkbox"/> Male	2) Current Marital Status <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	3) Student Status <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-time student <input type="checkbox"/> Not a student
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Staff Initials: _____

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<p>4) Employment Status</p> <p><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</p> <p>Employer:</p> <p>_____</p>	<p>5) Pharmacy of Choice:</p> <p>_____</p> <p>Name _____</p> <p>_____</p> <p>City/State _____</p>	<p>6) Gross annual (before taxes) household income? (include spouse)</p> <p>\$ _____ <input type="checkbox"/> No income</p> <p>6a) How many people (including yourself) does your income support? (if you are pregnant count unborn baby(ies))</p> <p>_____</p>	
<p>7) Race (check all that apply)</p> <p><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: _____</p>	<p>8) Ethnicity</p> <p><input type="checkbox"/> Hispanic/Latino/Latina <input type="checkbox"/> Not Hispanic/Latino</p>	<p>9) Migrant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10) US Veteran?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>11) United States Citizen or Legal Immigrant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12) Public Housing Resident?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>13) Homeless</p> <p><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: _____</p>	<p>14) Gender Identity</p> <p><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</p>	<p>15) Sexual Orientation?</p> <p><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</p>	<p>16) Referral Source</p> <p><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 _____</p>

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: _____

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