Charles Drew HEALTH CENTER, INC.

This Box for Staff Use Only:
Careful Contact: ☐ Yes ☐ No

Patient Registration Form

Section 1: Patient Information

First name: _____ Last name: _____ Middle initial: _____

Social Security #: _____ Sex assigned at birth: _____ Birthdate: _____ Age: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____ Alt. Phone: _____

Emergency Contact: _____ Relationship to patient: _____ Phone: _____

Primary language spoken in the home: _____ Interpreter needed: ○ No ○ Yes

Please select one answer per question and provide additional information when required:

Are you a student?	○ No	○ Yes, which school: _____	
Are you a veteran?	○ No	○ Yes	
Are you a migrant farm worker?	○ No	○ Yes	○ Seasonal
Are you Hispanic, Latino, or Chicano?	○ No	○ Yes	○ Refuse to report
Is this visit a result of work injury?		○ No	○ Yes
Is this visit a result of a car accident?		○ No	○ Yes

We must be able to contact you to give you results. Please check all ways we may contact you:

- ☐ Call home
- ☐ Call work
- ☐ Call home as "Heidi"
- ☐ Call cell phone
- ☐ Permission to leave message
- ☐ Mail at home
- ☐ Plain envelope
- ☐ Email
- ☐ Other - please specify: _____

Please check which of the following best describes your current housing. Please select only one:

- ○ Living on the streets
- ○ "Doubling Up" with family or friends
- ○ Transitional housing
- ○ Home-owner/Renting
- ○ Rehabilitations facility
- ○ Homeless shelter
- ○ Public housing high rise or low rise
- ○ Section 8 housing
- ○ Other - please specify: _____

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

- ○ White
- ○ Black or African American
- ○ Native Hawaiian
- ○ Asian
- ○ Pacific Islander
- ○ More than one race
- ○ American Indian or Native Alaskan
- ○ Unknown, not listed, or refuse to report

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

- ○ Straight / Heterosexual
- ○ Bisexual
- ○ Lesbian, gay, or homosexual
- ○ Don't know
- ○ Something else
- ○ Choose not to disclose

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

- ○ Male
- ○ Female
- ○ Transgender male / female-to-male
- ○ Transgender female / male-to-female
- ○ Other
- ○ Choose not to disclose

Section II: Financially Responsible Party Information

Only complete this section if different from patient. If not, please move on to next secction.

First name: _____ Last name: _____ Middle initial: _____

Relationship to patient: _____ Birthdate: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____ Alt. Phone: _____

Responsible Party's Social Security #: _____ Responsible Party's Drivers License #: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Section III: Patient's Household Information

Please ***circle*** your family size and annual household income range (should be in the same row).

Family Size:	Annual Income Ranges:					
1	$0-12,140	$12,141-15,175	$15,176-18,210	$18,211-21,245	$21,246-24,280	Over $24,280
2	$0-16,460	$16,461-20,575	$20,576-24,690	$24,691-28,805	$28,806-32,920	Over $32,920
3	$0-20,780	$20,781-25,975	$25,976-31,170	$31,171-36,365	$36,366-41,560	Over $41,560
4	$0-25,100	$25,101-31,375	$31,376-37,650	$37,651-43,925	$43,926-50,200	Over $50,200
5	$0-29,420	$29,421-36,775	$36,776-44,130	$44,131-51,485	$51,486-58,840	Over $58,840
6	$0-33,740	$33,741-42,175	$42,176-50,610	$50,611-59,045	$59,046-67,480	Over $67,480
7	$0-38,060	$38,061-47,575	$47,576-57,090	$57,091-66,605	$66,606-76,120	Over $76,120
8	$0-42,380	$42,380-52,975	$52,976-63,570	$63,571-74,165	$74,166-84,760	Over $84,760

**For patients who would like to apply for sliding fee scale discounts, actual income will be verified.*

Is the patient the head-of-household? ○ No ○ Yes

Is the head-of-household the same as the financially responsible person? ○ No ○ Yes

If the head-of-household is different from the financially responsible person,
please complete the following information for head-of-household:

First name: _____ Last name: _____ Middle initial: _____

Relationship to patient: _____ Birthdate: _____ Sex: _____

Preferred Language: _____

Section IV: Other Required Information

How were you referred to us?

☐ Physician ☐ School ☐ Hospital ☐ Employee ☐ Work
☐ TV ☐ Radio ☐ WIC ☐ Homeless ☐ Friend
☐ Omaha Healthy Start ☐ Current CDHC patient
☐ Other - please specify: _____

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.

Signed: _____ Date: _____