Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

This Box for Staff Use Only:
Careful Contact: ☐ Yes ☐ No
School-Based: ☐ Yes ☐ No
Barrier: ____________

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

Last name: ____________ First name: ____________ Middle initial: ______

Preferred name: ____________ Social Security #: ____________ Birthdate: ____________ Age: ______

Sex assigned at birth: ____________ School: ____________

Address: ____________ Apt #: ______ City: ____________ State: ______ Zip: ______

Please fill out any/all contact methods. Check box for preferred contact method: ☐ Home phone: ____________

☐ Cell phone: ____________ ☐ Alt. phone: ____________ ☐ Email: ____________

Emergency Contact: ____________ Relationship to patient: ____________ Phone: ____________

Preferred language: ____________ Interpreter needed: ☐ No ☐ Yes

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

☐ Male
☐ Female
☐ Transgender male / female-to-male
☐ Transgender female / male-to-female
☐ Something Else
☐ Choose not to disclose
☐ Don't know / Not applicable

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

☐ Straight / Heterosexual
☐ Bisexual
☐ Lesbian, gay, or homosexual
☐ Something else
☐ Choose not to disclose
☐ Don't know / Not applicable

Please check which of the following best describes your preferred pronoun:

☐ He, Him, His
☐ She, Her, Hers
☐ They, Them, Theirs
☐ Ze, Hir
☐ Declined to answer
☐ Unknown
☐ Other: ____________

Please provide information on your medical provider:

Who is your primary medical provider: ____________ ☐ None/Unknown

Address: ____________ Ste #: ______ City: ____________ State: ______ Zip: ______

Please provide information on your dental provider:

Who is your primary dental provider: ____________ ☐ None/Unknown

Address: ____________ Ste #: ______ City: ____________ State: ______ Zip: ______

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

☐ Homeless shelter
☐ Transitional housing
☐ "Doubling up" with family or friends
☐ Living on the streets
☐ Public, mixed-income, or low-income housing
☐ Home owner/Renting
☐ Other - please specify: ____________

Please answer the following questions:

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

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

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

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

- ☐ Hispanic, Latino, or Chicano
- ☐ Non-Hispanic, Latino, or Chicano
- ☐ Refuse 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'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	$0-12,490	$12,491-15,613	$15,614-18,735	$18,736-21,858	$21,859-24,980	Over $24,981
2	$0-16,910	$16,911-21,138	$21,139-25,365	$25,366-29,593	$29,594-33,820	Over $33,821
3	$0-21,330	$21,331-26,663	$26,664-31,995	$31,996-37,328	$37,329-42,660	Over $42,661
4	$0-25,750	$25,751-32,188	$32,189-38,625	$38,626-45,063	$45,064-51,500	Over $51,501
5	$0-30,170	$30,171-37,713	$37,714-45,255	$45,256-52,798	$52,799-60,340	Over $60,341
6	$0-34,590	$34,591-43,238	$43,239-51,885	$51,886-60,533	$60,534-69,180	Over $69,181
7	$0-39,010	$39,011-48,763	$48,764-58,515	$58,516-68,268	$68,269-78,020	Over $78,021
8	$0-43,430	$43,431-54,288	$54,289-65,145	$65,146-76,003	$76,004-86,860	Over $86,861

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

Section III: Responsible Party Information

Only complete this section if the responsible party is different from patient.

Last name: ______________________ First name: ______________________ Middle initial: ________

Social Security #: ______________________ Birthdate: ______________ Age: ________ Sex assigned at birth: ________

Relationship to patient: ____

Address: ______________________ Apt #: ________ City: ______________________ State: ______ Zip: ________

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

Email address: ______________________________ Preferred language: ______________________

Section IV: Insurance Information

Insurance name: ______________________________ Policy number/Enrollment ID: ______________________

Group ID: ______________________________ Member ID: ______________________________

Section V: Signature and Certification

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: ______________