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

First Name: ____________ Last Name: ____________

Preferred Name: ____________ Middle Initial: ____________

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

School Attending: ____________
If applicable

Address: ____________ City: ____________ State: ______ Zip: ______

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

☐ Cell Phone: ____________ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: ____________ May we leave a voicemail? ☐ Yes ☐ No

Email Address: ____________

Emergency Contact: ____________

Relationship to Patient: ____________ Phone Number: ____________

Preferred Language: ____________ Interpreter Needed?: ☐ Yes ☐ No

How did you hear about Charles Drew Health Center, Inc.? ____________

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

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

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

PATIENT REGISTRATION FORM

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 provide information on your medical provider:

Primary Medical Provider: ______________________________ [ ] None/Unknown

Address: ______________________ City: ______________ State: ________ Zip: ________

Please provide information on your dental provider:

Primary Dental Provider: ______________________________ [ ] None/Unknown

Address: ______________________ City: ______________ State: ________ Zip: ________

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

- [ ] Homeless shelter
- [ ] Transitional housing
- [ ] Doubling up
- [ ] Street
- [ ] Section 8
- [ ] Public housing
- [ ] Rent/Own

Please answer the following questions:

Are you a veteran? [ ] Yes [ ] No

Are you a migrant farm worker? [ ] Yes [ ] No [ ] Seasonal

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

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

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

Effective: July, 15 2020

PATIENT REGISTRATION FORM

SECTION II: PATIENT HOUSEHOLD INFORMATION

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

Family Size:	Annual Income Ranges:					
1	$0 - 12,760	$12,761 - 15,950	$15,951 - 19,140	$19,141 - 22,330	$22,331 - 25,550	Over $25,550
2	$0 - 17,240	$17,241 - 21,550	$21,551 - 25,860	$25,861 - 30,170	$30,171 - 34,480	Over $34,480
3	$0 - 21,720	$21,721 - 27,150	$27,151 - 32,580	$32,581 - 38,010	$38,011 - 43,440	Over $ 43,440
4	$0 - 26,220	$26,221 - 32,750	$32,751 - 39,300	$39,301 - 45,850	$45,851 - 52,400	Over $52,400
5	$0 - 30,680	$30,681 - 38,350	$38,351 - 46,020	$46,021 - 53,690	$53,691 - 61,360	Over $61,360
6	$0 - 35,150	$35,151 - 43,950	$43,951 - 52,740	$52,741 - 61,530	$61,531 - 70,320	Over $70,320
7	$0 - 39,640	$39,641 - 48,550	$48,551 - 59,460	$59,461 - 69,370	$69,371 - 79,280	Over $79,280
8	$0 - 44,120	$44,121 - 55,150	$55,151 - 66,180	$66,181 - 77,210	$77,212 - 88,240	Over $88,240

SECTION III: RESPONSIBLE PARTY INFORMATION

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

First Name: ______________________ Last Name: ______________________

Preferred Name: ______________________ Middle Initial: ________

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

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

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

☐ Cell Phone: ______________________ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: ______________________ May we leave a voicemail? ☐ Yes ☐ No

Email Address: ______________________

Preferred Language: ______________________ Interpreter Needed?: ☐ Yes ☐ No

Insurance Name: ______________________ Policy number/Enrollment ID: ______________________

Group ID: ______________________ Member ID: ______________________

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: __________