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): _____

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

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

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: _____

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

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 check which of the following best describes your housing status:

Are you homeless? ☐ Yes ☐ No

If yes, please describe your housing status:

☐ Homeless shelter ☐ Street homeless ☐ Transitional ☐ Doubling up

☐ Permanent supportive housing ☐ Other homeless: _____

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Please answer the following questions:

Are you a veteran? ☐ Yes ☐ No

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

Are you attending school? ☐ Yes ☐ No

If yes, which school are you attending: _____

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

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **MARK** your family size and household income range (first find family size then find income range in same row)

Family Size:	Annual Income Ranges:					
1	☐ $0 - 12,880	☐ $12,881 - 16,100	☐ $16,101 - 19,320	☐ $19,321 - 22,540	☐ $22,541 - 25,760	☐ Over $25,760
2	☐ $0 - 17,420	☐ $17,421 - 21,775	☐ $21,776 - 26,130	☐ $26,131 - 30,485	☐ $30,486 - 34,840	☐ Over $34,840
3	☐ $0 - 21,960	☐ $21,961 - 27,450	☐ $27,451 - 32,940	☐ $32,941 - 38,430	☐ $38,431 - 43,920	☐ Over $43,920
4	☐ $0 - 26,500	☐ $26,501 - 33,125	☐ $33,126 - 39,750	☐ $39,751 - 46,375	☐ $46,376 - 53,000	☐ Over $53,000
5	☐ $0 - 31,040	☐ $31,041 - 38,800	☐ $38,801 - 46,560	☐ $46,561 - 54,320	☐ $54,321 - 62,080	☐ Over $62,080
6	☐ $0 - 35,580	☐ $35,581 - 44,475	☐ $44,476 - 53,370	☐ $53,371 - 62,265	☐ $62,266 - 71,160	☐ Over $71,160
7	☐ $0 - 40,120	☐ $40,121 - 50,150	☐ $50,151 - 60,180	☐ $60,181 - 70,210	☐ $70,211 - 80,240	☐ Over $80,240
8	☐ $0 - 44,660	☐ $44,661 - 55,825	☐ $55,826 - 66,990	☐ $66,991 - 78,155	☐ $78,156 - 89,320	☐ Over $89,320

SECTION III: INSURANCE INFORMATION

Insurance Name: _____ Policy number/Enrollment ID: _____

Group ID: _____ Member ID: _____

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SECTION IV: FINANCIAL RESPONSIBLE PARTY INFORMATION

Should match insurance card, if applicable. 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): _____

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

SECTION V: EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

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

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: _____