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 current gender:

Male Female Undifferentiated Unknown

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

Male Female Transgender male/female-to-male Transgender female/male-to-female
Genderqueer Undifferentiated Unknown Choose not to disclose

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 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:

Own | Rent | Public housing (high rise or low rise) | Homeless *(see below)*

If you are homeless, please further describe your housing status:

Homeless shelter | Street homeless | Transitional | Doubling up

Permanent supportive housing | Other homeless: ______________________

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 Indian | Black or African American | Chinese

Filipino | Guamanian or Chamorro | Japanese | Korean

Native Hawaiian | Samoan | Vietnamese | Other Asian

Other 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:

Chicano | Cuban | Mexican | Mexican American

Puerto Rican | Not Hispanic, Latino/a, or Spanish origin | Other Hispanic | Unreported/Chose not to disclose ethnicity

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-$15,960	$15,960.01-$19,949.99	$19,950-$23,939.99	$23,940-$27,929.99	$27,930-$31,920	Over $31,921
2	$0-$21,640	$21,640.01-$27,049.99	$27,050-$32,459.99	$32,460-$37,869.99	$37,870-$43,280	Over $43,281
3	$0-$27,320	$27,320.01-$34,149.99	$34,150-$40,979.99	$40,980-$47,809.99	$47,810-$54,640	Over $54,641
4	$0-$33,000	$33,000.01-$41,249.99	$41,250-$49,499.99	$49,500-$57,749.99	$57,750-$66,000	Over $66,001
5	$0-$38,680	$38,680.01-$48,349.99	$48,350-$58,019.99	$58,020-$67,689.99	$67,690-$77,360	Over $77,361
6	$0-$44,360	$44,360.01-$55,449.99	$55,450-$66,539.99	$66,540-$77,629.99	$77,630-$88,720	Over $88,721
7	$0-$50,040	$50,040.01-$62,549.99	$62,550-$75,059.99	$75,060-$87,569.99	$87,570-$100,080	Over $100,081
8	$0-$55,720	$55,720.01-$69,649.99	$69,650-$83,579.99	$83,580-$97,509.99	$97,510-$111,440	Over $111,441

SECTION III: INSURANCE INFORMATION

Insurance Name: ______________________________ Policy Number/Enrollment ID: ______________________

Group ID: ______________________________ Member ID: ______________________

SECTION IV: EMERGENCY CONTACT INFORMATION

Emergency Contact: ____

Relationship to Patient: ______________________ Phone Number: ______________________

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

SECTION V: 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

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: ____/____/________