Patient Registration

Petaluma Health Center

Today's Date ____/____/____

PATIENT INFORMATION

Last Name _____ First _____ M.I. _____

Other Names _____ Preferred Name _____

Address _____

City _____ State _____ Zip Code _____

Cell phone #: (____) ____-____ Alt. phone #: (____) ____-____

Can we text you? ☐ Yes ☐ No Can we leave a voice message? ☐ Yes ☐ No

Date of Birth ____/____/____ Sex: ☐ Male ☐ Female ☐ Decline

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed ☐ Legally Separated

Social Security Number ____-____-____

Employer Name _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self Employed ☐ Retired
☐ Active Military Duty ☐ Unknown

Student: ☐ Full-Time ☐ Part-Time ☐ Not Student

Language Preference? ☐ English ☐ Spanish ☐ ASL ☐ Other

Email Address: _____ Mobile App Access: ☐ Yes ☐ No

RESPONSIBLE PARTY

(If patient is a minor -17 & younger - parent or guardian complete this section.)

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Last Name _____ First _____ M.I. _____

Custodial Responsibility: ☐ Self ☐ Parent ☐ Other _____

(Please provide custody forms & Photo ID.)

Date of Birth ____/____/____

Address _____

City _____ State _____ Zip Code _____

Cell phone #: (____) ____-____

Alt. phone #: ☐ Home ☐ Work ☐ Cell (____) ____-____

EMERGENCY CONTACT *(other than responsible party)*

Relationship to Patient: ☐ Parent ☐ Other _____

Last Name _____ First _____ M.I. _____

Cell phone #: (____) ____-____

Alt. phone #: ☐ Home ☐ Work ☐ Cell (____) ____-____

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PRIMARY INSURANCE INFORMATION

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Primary Medical Insurance _____ Policy Number _____

Insured Last Name _____ First _____ M.I. _____

Date of Birth of Insured ____/____/____ Insured SSN ____-____-____

Cell phone #: (____) ____-____

Alt. phone #: ☐ Home ☐ Work ☐ Cell (____) ____-____

SECONDARY INSURANCE INFORMATION

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Secondary Medical Insurance _____ Policy Number _____

Insured Last Name _____ First _____ M.I. _____

Date of Birth of Insured ____/____/____ Insured SSN ____-____-____

Cell phone #: (____) ____-____

Alt. phone #: ☐ Home ☐ Work ☐ Cell (____) ____-____

PHARMACY

☐ PHC Pharmacy ☐ I'd like to use an outside pharmacy

Name of Pharmacy _____

Pharmacy Address _____

City _____ State _____ Zip Code _____

HOUSEHOLD INFORMATION

This information is very important for our funding as a Federally Qualified Health Center, and provides information that helps us better serve our patients and our community.

- Annual household gross income: $ _____

☐ Decline to State

- Number of children & adults dependent on this income: _____

☐ Decline to State

- Your Race *(Please check one)*: ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Caucasian/White ☐ More than one race ☐ Choose not to disclose ☐ Other Pacific Islander ☐ Native Hawaiian

- Your Ethnicity *(Please check one)*: ☐ Non-Hispanic ☐ Hispanic ☐ Choose not to disclose

- Are you a United States military veteran? ☐ Yes ☐ No

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HOUSEHOLD INFORMATION *(continued)*

- In the past 2 years, have you or your financially dependent family members been a migrant worker in agriculture (temporarily move to another town to find work in agriculture like in vineyards or fruit picking)? ☐ Yes ☐ No
- In the past 2 years, have you or your dependent family members been a seasonal worker in agriculture (do not move from town to town to work, but only work certain seasons in agriculture like in vineyards or fruit picking)? ☐ Yes ☐ No
- I am: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Don't know
  ☐ Choose not to disclose ☐ Something Else _____
- Have you been homeless or in supportive housing at any time since January of this year?
  ☐ Yes ☐ No
  Date you became homeless: ____/____/____
  ☐ Homeless Shelter ☐ Shared/Couch Surfing ☐ Street
  ☐ Transitional Housing ☐ Supportive Housing ☐ Other

HOW DID YOU HEAR ABOUT US?

☐ I'm a Current Patient ☐ Internet ☐ Radio ☐ Advertisement
☐ Another Patient/Friend ☐ Other