STAFF USE ONLY

CHART #

PATIENT REGISTRATION AND INFORMATION
(Please Complete Entire Form)

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH:	AGE:	SEX (at birth): ☐ MALE ☐ FEMALE	SS#

ADDRESS:	CITY:	ZIP:

TOTAL HOUSEHOLD INCOME:	NUMBER OF PEOPLE IN HOUSEHOLD:

HOME PHONE:	CELL PHONE:	WORK PHONE:

EMAIL:	May we e-mail you? ☐ YES ☐ NO	May we text you? ☐ YES ☐ NO

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated

ETHNICITY: ☐Not Hispanic, Latino/a, or Spanish Origin ☐Other Hispanic, Latino/a, or Spanish Origin
☐Mexican, Mexican American, Chicano/a ☐Cuban ☐Puerto Rican ☐Decline to State

RACE: ☐Asian Indian ☐Chinese ☐Filipino ☐Korean ☐Vietnamese ☐Asian, other ☐Hawaiian, Native
☐Pacific Islander, other ☐Guamanian or Chamorro ☐Samoan ☐Black or African American ☐American Indian or Alaska Native
☐White ☐Other Race ☐Decline to State

CHOICE OF PHARMACY:

SPECIAL POPULATION: ☐ Migratory/Seasonal Agricultural Workers ☐ Individuals Experiencing Homelessness
☐ Residents of Public Housing ☐ Individuals with Limited English Proficiency ☐ Children (less than 18 years)

SEXUAL ORIENTATION: ☐ Lesbian or Gay ☐ Heterosexual (or straight) ☐ Bisexual ☐ Something else
☐ Don't know ☐ Chose not to disclose ☐ Unknown

GENDER IDENTITY: ☐ Male ☐ Female ☐ Transgender Man/Transgender Male/Transgender Masculine
☐ Other ☐ Chose not to disclose ☐ Unknown ☐ Transgender Woman/Transgender Female/Transgender Feminine

ARE YOU EXPERIENCING HOMELESSNESS? (If you are, please select one of the following options, FTOC may be able to help)
☐ Homeless Shelter (330h awardees only) ☐ Transitional (330h awardees only) ☐ Doubling Up (330h awardees only)
☐ Streets (330h awardees only) ☐ Permanent Supportive Housing (330h awardees only) ☐ Other (330h awardees only)
☐ Unknown (330h awardees only)

ARE YOU A VETERAN? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US? ☐ Search engine (Google, Yahoo, etc) ☐ Social media (Facebook, Instagram)
☐ Customer review site (Yelp) ☐ Friends/Family ☐ Internal referral (FTOC Service) ☐ Families Together website
☐ Community outreach ☐ Health fair/event ☐ External referral (please specify) ☐ Other (please specify)
☐ Other (please specify)

EMERGENCY CONTACT:	RELATIONSHIP:	PHONE NUMBER:

WHAT IS YOUR PREFERRED LANGUAGE? ☐ English ☐ Spanish ☐ Other_____

Please select one or more of the following if you have special communication needs/accommodations: Low vision, hard of hearing, deaf, deaf/blind/none of the above

WHICH DESCRIBES YOU (select all that apply): ☐ Low vision ☐ Hard of hearing ☐ Deaf ☐ Deaf/Blind ☐ None of the above

ADVANCE DIRECTIVES

Advance Directives are legal documents that provide instruction regarding your medical care decisions. We encourage you to discuss your treatment decisions with the medical staff.

Would you like to receive more information regarding Advance Directives? ☐ YES ☐ NO

PHI Designee

I allow the below designated person to verbally or in person have a release of my personal health information to these individuals for the purpose of treatment including making appointments and all other functions normally associated with individual patient care, payment, and health care operations. The person(s) listed above on this form are required to provide a valid government-issued identification in order to ensure identity. This form will remain effective for one year from the date it is signed.

Name of Designee:	Relationship to Patient:	Phone Number:	Effective Date (if less than one year) Specify:

By Signing below, I attest that the information stated above to be true to the best of my knowledge		
PRINT NAME:	SIGN:	DATE:
GUARDIAN:	RELATIONSHIP:	
SIGN:	DATE:	