PLACE LABEL HERE

FAMILY HEALTH CENTERS OF SAN DIEGO

INTERPRETER NEEDED? YES ☐ NO ☐ N/A ☐

PATIENT REGISTRATION FORM (PLEASE PRINT)

Patient First Name: **Last Name:** **Middle:**

For Patients Under 18: Name of Parent/Legal Guardian

Home Address: **City:** **State:** **ZIP Code:**

Mailing Address: ☐ *Same as Home*

Pronouns
☐ He/Him
☐ She/Her
☐ They/Them
☐ Other

Sex at Birth: ☐M ☐F
Gender Identity: ☐M ☐F ☐Gender Queer/Non-Binary
Legal Gender: ☐M ☐F ☐X
Sexual Orientation:
☐ Straight or Heterosexual ☐ Lesbian
☐ Gay or Homosexual ☐ Bisexual ☐ Asexual
☐ Something else ☐ Don't know ☐ Decline

Date of Birth: ____ / _____ / _____

Home Phone: **Cell:** **ID/DL#:**

Preferred Contact: (check one)
☐ Home ☐ Cell ☐ Email ☐ Text ☐ None

Email:

Social Security Number: - -

Emergency Contact Name: ☐ *Decline* **Relationship:** **Emergency Phone:**

ETHNICITY:

☐ Mexican/Mexican American/Chicano
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a, or Spanish origin
☐ Non-Hispanic, Latino/a, or Spanish origin
☐ Middle Eastern/North African
☐ Don't know
☐ Decline

RACE:

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ American Indian/Alaska Native
☐ Black/African American
☐ White
☐ More than one race
☐ Don't know
☐ Decline

PRIMARY LANGUAGE:

☐ English ☐ Spanish ☐ Sign Language ☐ Other _____

EDUCATION: (maximum level)

☐ Grade _____ ☐ Grade 12 ☐ College
☐ Some College ☐ Post Graduate

MARITAL STATUS: (for patients over 16)

☐ Married ☐ Domestic Partner ☐ Single
☐ Divorced ☐ Separated ☐ Head of Household
☐ Widowed ☐ Unknown

VETERAN STATUS: (MILITARY)

Are you a veteran of the U.S. Armed Forces? DD214? ☐ Yes ☐ No
Are you eligible to receive medical care from the VA? ☐ Yes ☐ No Year Discharged _____
Were you ever denied medical care by the VA? ☐ Yes ☐ No Status _____

If denied medical care, why? _____

If you tried to use the VA and were dissatisfied, what was the reason?

_____

BRANCH OF SERVICE:

☐ Army
☐ Navy
☐ Marines
☐ Air Force
☐ Coast Guard
☐ National Guard
☐ Merchant Marine
☐ Space Force

FAMILY HEALTH CENTERS OF SAN DIEGO

HOUSING STATUS:	EMPLOYMENT:	I LEARN BEST BY:
☐ Own or Rent ☐ No Permanent Housing (homeless) **If you checked "No Permanent Housing," where are you currently staying?** ☐ Shelter ☐ Staying with Family/Friends ☐ Streets ☐ Transitional ☐ Canyon ☐ Other _____ Homeless for how long? _____	☐ Employed ☐ Retired ☐ Part/Full-Time Student ☐ Unknown ☐ Unemployed **FARM WORKER:** ☐ Migrant ☐ Seasonal ☐ Neither	☐ Seeing ☐ Touching ☐ Hearing **OCCUPATION:** ☐ Current _____ ☐ Previous _____
NUMBER IN HOUSEHOLD: _____ **MONTHLY INCOME:** _____		**DISABLED:** ☐ Yes ☐ No

SIGNATURE: _____ **DATE:** _____