



Blessing Community Health Center

PATIENT REGISTRATION FORM

Personal Information

| | | | | | | |
|---|-------------|---|-----------------------|---|---|----------|
| Last Name: | First Name: | MI: | Date Of Birth: / / | Preferred Name: | May we leave voicemails? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Home Address: | | Apt#: | City: | State: | Zip: | Country: |
| Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell () - | | Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work () - | | Social Security: | | |
| Marital Status (Check One): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Life Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | Name of Spouse: | | Email: | | |
| | | What is your current work situation: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> Decline to answer | | Are you a student? <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> Not enrolled <input type="checkbox"/> Decline to answer | | |
| Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ | | Limited English? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Do you need a translator? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

INSURANCE INFORMATION

| | | |
|-----------------|--------------|--|
| Insurance Name: | Member ID #: | Is this your Primary or Secondary Insurance? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary |
|-----------------|--------------|--|

DEMOGRAPHIC INFORMATION

| | | |
|---|---|--|
| Race: <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Unknown/ Refuse to report <input type="checkbox"/> Decline to specify | | Are you of Hispanic origin? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No | If homeless, please specify: <input type="checkbox"/> Transitional Living <input type="checkbox"/> Street <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Doubling Up | |
| Do you reside in a housing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have an Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are you a Veteran of the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you a Seasonal Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No |

SEXUAL ORIENTATION AND GENDER IDENTITY

| | |
|---|---|
| Sex assigned at birth? <input type="checkbox"/> Male <input type="checkbox"/> Female | What is your Sexual Orientation? <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other: _____ <input type="checkbox"/> Gay, Lesbian, or homosexual <input type="checkbox"/> Choose not to disclose |
|---|---|

EMERGENCY CONTACT INFORMATION

| | | |
|------------------|-----------------------------------|--------------------------|
| Name of Contact: | Phone Number of Contact: () - | Relationship to Patient: |
|------------------|-----------------------------------|--------------------------|

HOW DID YOU HEAR ABOUT US?

| | | | | |
|----------------------------------|---|---------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Flyer | <input type="checkbox"/> Relative/ Friend | <input type="checkbox"/> Event/ Fair | <input type="checkbox"/> Insurance | <input type="checkbox"/> Google |
| <input type="checkbox"/> Walk-In | <input type="checkbox"/> Internet | <input type="checkbox"/> Social Media | <input type="checkbox"/> School | <input type="checkbox"/> Other: _____ |

PREFERRED PHARMACY INFORMATION?

| | | |
|-----------------------------|-------------------------|---------------------------------|
| Name of Preferred Pharmacy: | Pharmacy Intersections: | Pharmacy Phone Number: () - |
|-----------------------------|-------------------------|---------------------------------|

I certify that the above information is correct to the best of my knowledge

(Patient/ Parent/ Guardian Signature)

(Date)

FOR OFFICE USE ONLY

Registration Staff Signature: _____ Date: _____