Blessing Community Health Center

PATIENT REGISTRATION FORM

Personal Information

Last Name: First Name: MI:	Date Of Birth: / /	Preferred Name:		May we leavedetailedvoicemails? □Yes □No
Home Address: Apt#:	City:	State:	Zip:	Country:

Preferred Phone:□ Home □Cell ( ) -	Alternate Phone:□Home □Cell □Work ( ) -	Social Security:
Marital Status (Check One): □ Single □ Married □ Life Partner □ Divorced □ Separated □ Widowed	Name of Spouse:	Email:
	What is your current work situation: □Unemployed □Part-Time □Full-Time □Decline to answer	Are you a student? □Part-Time □Full-Time □Not enrolled □Decline to answer

Primary Language: □English □Spanish □Other:_____	Limited English? □ Yes □ No	Do you need a translator? □ Yes □ No

Annual Income

Income: □Weekly □Bi-Weekly □ Monthly □Annual	Total:

INSURANCE INFORMATION

Insurance Name:	Member ID #:	Is this your Primary or Secondary Insurance?□Primary □Secondary

DEMOGRAPHIC INFORMATION

Race: □ Black or African American □American Indian/Alaska Native □Filipino/Chinese□Other Pacific Islander □White/Hispanic□Other Asian □Samoan	Are you of Hispanic origin?□ Yes □ No

Are you homeless?□ Yes □No	If homeless, please specify: □ Transitional Living □ Street □Homeless Shelter □ Doubling Up
Do you reside in a housing facility? □ Yes □No	**Do you have an Advanced Directive?**□ Yes □ No

Are you a Veteran of the U.S. Armed Forces? □ Yes □ No	Are you a migrant worker? □ Yes □ No	Are you a Seasonal Worker? □ Yes □ No

SEXUAL ORIENTATION AND GENDER IDENTITY

Sex assigned at birth? □ Male □ Female	What is your Sexual Orientation? □ Straight or Heterosexual □Bisexual□Other:_____ □Gay, Lesbian, or homosexual □ Choose not to disclose

EMERGENCY CONTACT INFORMATION

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

HOW DID YOU HEAR ABOUT US?

□ Flyer □ Relative/ Friend □ Event/ Fair □ Insurance □ Google
□ Walk-In □ Internet □ Social Media □ School □ 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:_____