Fair Haven Community Health Care Shoreline Family Health Care

MR#_____

Patient Registration Form

☐ **New Patient** ☐ **Returning Patient**

Patient Information					
Last Name:	First Name:	Middle Name:			
Date of Birth:	Social Security #:	Preferred Name:			
Street Address:	City:	State:	Zip Code:		
Cell Phone #:	Home Phone #:	Work Phone #:			
Best Number to Use: ☐ Cell ☐ Home ☐Work	Send appointment reminders by text? ☐ Yes ☐ No	OK to leave voicemail? ☐ Yes ☐ No			
Email: ☐ No email		Preferred Language:			
Are you fluent in English?	☐ Yes	☐ No	Do you need an interpreter for your visit?	☐ Yes	☐ No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated			Employment Status: ☐ Employed full time ☐ Employed part time ☐ Retired ☐ Student full time ☐ Student part time ☐ Unemployed ☐ Other		
Employer:					

Patient Demographic Information					
What is your race?	☐ American Indian or Alaska Native	☐ Asian	☐ Black or African American		
	☐ Native Hawaiian	☐ Pacific Islander	☐ White		
	☐ Other	☐ Choose not to disclose			
What is your ethnicity?	☐ Hispanic or Latino	☐ Non-Hispanic or Latino	☐ Choose not to disclose		
What is your sex?	☐ Female	☐ Male	☐ Choose not to disclose		
What is your current housing?	☐ Rent or own home (by self or with family)	☐ Live permanently with someone who supports me	☐ Staying with family or friends		
	☐ Emergency shelter	☐ Transitional housing for homeless	☐ Other		
Family Financial Information	Family Household Size:	Household Income:			
	☐ Weekly	☐ Biweekly	☐ Monthly	☐ Annually	☐ Refused
Are you a U.S. Veteran?	☐ Yes	☐ No			

Emergency Contact Information		
Name:	Relationship to patient:	Phone #:

I give permission for my health care provider and staff to discuss issues related to my/my child's medical care with the following individuals. I understand that this permission applies to all aspects of my medical care unless otherwise specified.

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Pediatric Patient Parent/Guardian Information			
Parent/Guardian #1 First Name:		Parent/Guardian #2 First Name:	
Last Name:	DOB:	Last Name:	DOB:
Relationship to Patient:		Relationship to Patient:	
Lives with Patient? Yes/No/Other		Lives with Patient? Yes/No/Other	
Cell Phone #:	Work Phone #:	Cell Phone #:	Work Phone #:
Who is the custodial parent? □ #1 □ #2 □ Both *Please provide custody paperwork, if applicable*			

Insurance Information			
MEDICAL INSURANCE INFORMATION □ I currently have MEDICAL insurance □ I currently DO NOT have MEDICAL insurance □ I would like to apply for the SLIDING FEE SCALE		DENTAL INSURANCE INFORMATION □ I currently have DENTAL insurance □ I currently NOT have DENTAL insurance □ I would like to apply for the SLIDING FEE SCALE	
Medical Insurance Name:		Dental Insurance Name:	
Policy Holder Name:	DOB:	Policy Holder Name:	DOB:
Policy Number:		Policy Number:	
Group Number:		Group Number:	

Signature of Patient/Parent/Guardian **Date**

How did you hear about us?

Referred by □ Friend/Family Member □ Health Care Provider □ Emergency Room □ Internet Search
□ Facebook □ Advertisement □ Health Fair/Outreach □ Work or School □ Other_____

STAFF USE
Reviewed By:_____ **Scanned By:** _____