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 gender?	☐ Female	☐ Male	☐ Gender non-conforming	☐ Genderqueer
	☐ Intersex	☐ Transsexual	☐ Transgender Female	☐ Transgender Male
	☐ Other	☐ Choose not to disclose		
What are your pronouns?	☐ She, her, hers	☐ He, him, his	☐ They, them, theirs	
What is your sexual orientation?	☐ Bisexual	☐ Lesbian, Gay or homosexual	☐ Heterosexual/Straight	
	☐ Something else	☐ Choose not to disclose	☐ Don't know	
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: _____