



PATIENT REGISTRATION FORM

Legal Name: Last	First	MI
Preferred Name:		
Date of Birth <i>Month Day Year</i> / /	Social Security #	
<p>While 1st Choice Healthcare recognizes our patients by their preferred name, many insurance companies and legal entities unfortunately do not. Please be aware that the legal name you have listed must be used on documents pertaining to insurance, billing and correspondence. If your preferred name is different, please let us know.</p>		

Your answers to the following questions will help us reach you quickly and discreetly with important information

Mailing Address	City	State	ZIP
Street Address (if different from above)	City	State	ZIP
Home Phone () -	Cell Phone () -	Work Phone () -	Preferred Number to contact <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
AUTOMATED APPOINTMENT REMINDERS			
Preferred Method of contact for automated appointment reminders <input type="checkbox"/> Voice <input type="checkbox"/> Text		Preferred Phone number for automated appointment reminders <input type="checkbox"/> Home <input type="checkbox"/> Cell	
Email Address			

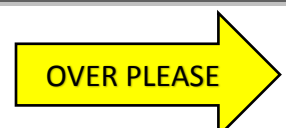
As a Federally Qualified Health Center, 1st Choice healthcare, Inc., is required to collect income information on all patients even if you choose not to participate in the Sliding Fee Scale Program*. Please choose your household gross income range:

<input type="checkbox"/> \$0 - \$11,880	<input type="checkbox"/> \$11,881 - \$23,881	<input type="checkbox"/> \$23,882 - \$34,882
<input type="checkbox"/> \$34,883 - \$45,883	<input type="checkbox"/> \$45,884 - \$56,884	<input type="checkbox"/> \$56,885 - \$67,885
<input type="checkbox"/> \$67,886 - \$77,886	<input type="checkbox"/> \$77,887 - \$88,887	<input type="checkbox"/> \$88,888 - \$99,888
<input type="checkbox"/> \$99,889 - \$110,889	<input type="checkbox"/> \$110,890 - Above	<input type="checkbox"/> Choose not to disclose

**Please ask the receptionist for more information on the Sliding Fee Scale Program*

Household members

Full Name	Date of Birth	Gender	Relationship to Patient





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Emergency Contact *(Preferably someone not living with you)*

Name			
Address		City	State ZIP
Phone () -		Relationship to patient	
Additional Contact Information			
Name			
Address		City	State ZIP
Phone () -		Relationship to patient	

If the patient is under the age of 18, this section must be completed

Responsible Party Name			
Address		City	State ZIP
Phone () -		Date of Birth <i>Month Day Year</i> / /	
Social Security #		Relationship to patient	
Responsible Party Employer Name			
Employer Address		City	State ZIP
Employer Phone () -			



PATIENT REGISTRATION FORM

Patient Employer Information

Name of Employer			
Address		City	State ZIP
Phone () -			

Method of Payment/Policy Holder Information

Method of Payment (check all that apply) Self Pay Sliding Fee Private Insurance Medicaid ARKids Medicare

Policy Holder Name (As it appears on the insurance Card)			
Address		City	State ZIP
Phone () -		Date of Birth Month Day Year / /	
Social Security #		Relationship to Patient	

<p>1) Language(s)</p> <p><input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Spanish <input type="checkbox"/> Hebrew <input type="checkbox"/> Chinese <input type="checkbox"/> Italian <input type="checkbox"/> Arabic <input type="checkbox"/> Korean <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Indian <input type="checkbox"/> Thai <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Portuguese <input type="checkbox"/> Other <input type="checkbox"/> Tagalog <input type="checkbox"/> Urdu</p> <p>Translator needed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2) Ethnicity</p> <p><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Refused to report</p>	<p>3) Race</p> <p><input type="checkbox"/> American Indian/Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unreported/refused to report</p>	<p>4) Marital Status</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated</p>
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<p>5) Employment/Student Status</p> <p><input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Student full time <input type="checkbox"/> Student part time <input type="checkbox"/> Not employed <input type="checkbox"/> Not a student <input type="checkbox"/> self-employed <input type="checkbox"/> retired <input type="checkbox"/> active military duty</p>	<p>6) Are you or a family member a seasonal farm worker?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>7) Veteran Status</p> <p><input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran</p>	<p>8) Are you homeless?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If yes, please specify)</i> <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Street <input type="checkbox"/> Doubling up</p> <p>When did you become homeless? Month Day Year / /</p>
<p>9) Do you have an Advance Directive (Living Will)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If not would you like information on one?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>10) Do you live in public housing?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>11) What was your gender at birth?</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>12) Do you identify as transgender?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>13) What is your current gender identity?</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose</p>		<p>14) Do you think of yourself as</p> <p><input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose</p>	

Patient OR Parent/Guardian Signature

Date