Patient Registration Form

Legal Name: Last	First	MI
Preferred Name:		
Date of Birth *Month Day Year* / /	Social Security #	

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.

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

Mailing Address	City	State	County	ZIP
Street Address (if different from above)	City	State	County	ZIP

Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -	Preferred Number to contact [ ] Home [ ] Cell [ ] Work

AUTOMATED APPOINTMENT REMINDERS

Preferred Method of contact for automated appointment reminders [ ] Voice [ ] Text	Preferred Phone number for automated appointment reminders [ ] Home [ ] 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:

[ ] $0 - $11,880	[ ] $11,881 - $23,881	[ ] $23,882 - $34,882
[ ] $34,883 - $45,883	[ ] $45,884 - $56,884	[ ] $56,885 - $67,885
[ ] $67,886 - $77,886	[ ] $77,887 - $88,887	[ ] $88,888 - $99,888
[ ] $99,889 - $110,889	[ ] $110,890 - Above	[ ] 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 *Month Day Year* / /		
Social Security #	Relationship to patient		
Responsible Party Employer Name			
Employer Address	City	State	ZIP
Employer Phone ( ) -			

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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

1) Language(s)

[ ] English
[ ] Spanish
[ ] Chinese
[ ] Arabic
[ ] German
[ ] Indian
[ ] Japanese
[ ] Portuguese
[ ] Tagalog
[ ] Urdu
[ ] French
[ ] Hebrew
[ ] Italian
[ ] Korean
[ ] Russian
[ ] Thai
[ ] Vietnamese
[ ] Other

Translator needed?
[ ] Yes
[ ] No

2) Ethnicity

[ ] Hispanic/Latino

[ ] Not Hispanic/Latino

[ ] Refused to report

3) Race

[ ] American Indian/Alaska native
[ ] Asian
[ ] Native Hawaiian
[ ] Black/African American
[ ] White
[ ] Other Pacific Islander
[ ] Marshallese
[ ] Unreported/refused to report

4) Marital Status

[ ] Single
[ ] Married
[ ] Divorced
[ ] Widowed
[ ] Legally Separated

OVER PLEASE

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5) Employment Status	6) Are you or a family member a seasonal farm worker?	7) Veteran Status	8) Are you homeless?
[ ] Employed full time [ ] Employed part time [ ] Not employed [ ] self-employed [ ] retired [ ] active military duty **Student Status** [ ] Student full time [ ] Student part time [ ] Not a student	[ ] Yes [ ] No	[ ] Veteran [ ] Not a Veteran	[ ] Yes [ ] No ***(If yes, please specify)*** [ ] Homeless Shelter [ ] Street [ ] Doubling up **When did you become homeless?** *Month Day Year* / /
9) Do you have an Advance Directive (Living Will)? [ ] Yes [ ] No ***If not would you like information on one?*** [ ] Yes [ ] No	**10) Do you live in public housing?** [ ] Yes [ ] No	**11) What was your gender at birth?** [ ] Male [ ] Female	**12) Do you identify as transgender?** [ ] Yes [ ] No
13) What is your current gender identity? [ ] Male [ ] Female [ ] Transgender Male/Female-to-Male [ ] Transgender Female/Male-to-Female [ ] Other [ ] Choose not to disclose	**14) Do you think of yourself as** [ ] Straight (not lesbian or gay) [ ] Lesbian or Gay [ ] Bisexual [ ] Something else [ ] Don't know [ ] Choose not to disclose		

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Patient OR Parent/Guardian Signature **Date**