



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	County	ZIP
Street Address (if different from above)	City	State	County	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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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) Race</p> <p><input type="checkbox"/> American Indian/Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan</p>	<p>2) Race (ctd)</p> <p><input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Marshallese <input type="checkbox"/> Chose not to disclose</p> <hr/> <p>3) 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>	<p>4) Ethnicity</p> <p><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Hispanic/Latino/a, Spanish Origin COMBINED</p> <p><input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Declined to Specify</p>
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<p>5) Employment Status</p> <p><input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Not employed <input type="checkbox"/> self-employed <input type="checkbox"/> retired <input type="checkbox"/> active military duty</p> <p>Student Status</p> <p><input type="checkbox"/> Student full time <input type="checkbox"/> Student part time <input type="checkbox"/> Not a student</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></p> <p><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>		

Patient OR Parent/Guardian Signature

Date