Patient Registration Form

Patient Information

Patient's Last Name	First Name	Middle Name
Address		
City, State, ZIP		
Best way to contact you: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ________________________ Enroll in MyCare Online patient portal? ☐ Yes ☐ No		
Phone number: ____________________ ☐ Cell ☐ Home	OK to leave messages? ☐ Voice ☐ Text	
Alternate phone number: ____________________ ☐ Cell ☐ Home ☐ Work ☐ Other		
Patient date of birth:	Patient Social Security Number (if applicable):	

How confident are you filling out medical forms by yourself?

☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all	**Assistance needed?** ☐ **Yes** ☐ **No**

Responsible Party

Patient is the financially responsible person? ☐ Yes ☐ No - Complete the section below

Last Name	First Name	Middle Initial	Relationship to Patient
Address			
City, State, ZIP			
Best phone number to contact this person: ☐ Cell ☐ Home ☐ Work ☐ Other Phone number: ________________________			

For Patients Under 18 or Dependent Adults: Additional Parent/Legal Guardian/Caregiver/Conservator

Last Name	First Name	Middle Initial	Relationship to Patient
Address (if different than patient address above)			
City, State, ZIP			
Best phone number to contact this person: ☐ Cell ☐ Home ☐ Work ☐ Other Phone number: ________________________			

Emergency Contact (for minors, this must be different from the Responsible Party listed above)

Last Name	First Name	Middle Initial	Relationship to Patient
Best phone number to contact this person: ☐ Cell ☐ Home ☐ Work ☐ Other Phone number: ________________________			

Do you have other persons to add? If yes, a form can be provided at the reception desk.

Patient's Sex at birth:	Sexual Orientation:	Gender Identity:
☐ Male ☐ Female ☐ Intersex Transgender Preferred name: ______________	☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Do not know ☐ Choose not to disclose Something else, please describe: __________________________	☐ Female / Woman ☐ Male / Man ☐ Female-to-Male (FTM) / Transgender Male/Trans Man ☐ Male-to-Female (MTF) / Transgender Female/Trans Woman ☐ Genderqueer / Gender nonconforming ☐ Choose not to disclose ☐ Additional gender category or other, please specify: ____

Patient's Insurance

☐ Insured – Please present insurance card

☐ Uninsured

Household Income (for grant purposes)

Number of dependents including yourself? ☐ ____________

Family monthly income before taxes? ____________________

Check any benefits you get: ☐ None ☐ Public Assistance ☐ Retirement ☐ Other: ______________________

Pharmacy Information

What pharmacy do you want to use? ☐ Lombardi Pharmacy ☐ Dutton Pharmacy ☐ Vista Pharmacy
☐ Other: ___________________________________

Medication Insurance if different than regular insurance: ____

Additional Information

Patient street address if different from mailing address?

Race (check all that apply):
☐ African American / Black
☐ American Indian/Alaskan Native
☐ Asian
☐ Caucasian / White
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other: ___________________________________

Ethnicity Hispanic/Latino? ☐ Yes ☐ No ☐ Decline to specify

Primary Language ☐ English ☐ Spanish
☐ Other: ______________________

Do you need a translator for your visit?
☐ Yes ☐ No

Disability (check all that apply):

☐ None ☐ Learning ☐ Vision ☐ Mental ☐ Hearing ☐ Mobility ☐ Intellectual ☐ Developmental

Questions to Help You and Your Community

SRCH is a not-for-profit corporation. The grants we get help us give services to people who can't afford to pay full cost. Answering these questions will help us serve you AND your community.

Check all that apply to you:

☐ Seasonal agricultural worker: My main job is agriculture, and I don't work year-round
☐ Migrant agricultural worker: My main job is agriculture, I don't work year-round and I move to find my jobs
☐ Veteran
☐ Living in a homeless shelter
☐ Living on the street or in my car
☐ Staying temporarily with friends/family
☐ Living in transitional housing: temporary housing program with help to later transition into permanent housing
☐ Other homeless situation; please describe: ____

Sign to authorize

The information I gave on this form is true and correct to the best of my knowledge.

- I give consent for the employees at Santa Rosa Community Health (SRCH) to do the medical exams, procedures, treatments, and referrals they need to care for me.
- I agree to follow SRCH payment rules for the services I get.
- I know that I am responsible to pay for any services not covered by my insurance company.
- I know that I am responsible for understanding my insurance company rules.
- I authorize the release of any information SRCH needs to process my medical claims.
- I authorize the payment of any government benefits or insurance payments due to SRCH for services they give me.
- I give SRCH permission to review pharmacy records related to the health care I get.

By signing, I agree and consent to the above terms and conditions so my care team can provide all the care necessary to treat me.

For Dependent Adults, Conservator approval is required: X_____________________________________(**sign here**)

X ____ ____________________

Patient Signature (parent/guardian must sign for minors and dependent adults) Date