Do you need an interpreter and/or assistance completing this form?

Please check in with a reception team member for help.

Patient's Information

Last Name	First Name	Middle Name/ Initial
Preferred Name *(if applicable)*:	Patient's Pronouns:	Date of birth:
SSN/ITIN *(if applicable)*:		
Address:	City, State, ZIP	

Patient's Sex at Birth *(required for children under 5yrs)*:
☐ Female ☐ Male ☐ Intersex

Sexual Orientation:
☐ Asexual ☐ Lesbian ☐ Gay ☐ Don't know ☐ Straight/ Heterosexual
☐ Bisexual ☐ Pansexual ☐ Queer ☐ Something else
☐ Omnisexual ☐ Choose not to disclose

Gender Identity:
☐ Female/ Woman ☐ Male/ Man ☐ Questioning
☐ Transgender Female/ Trans Woman ☐ Choose not to disclose
☐ Transgender Male/Trans Man ☐ Other ____________
☐ Non-binary/ Genderqueer
☐ Two Spirit

Best way to contact you: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text

Email Address:

Primary Phone Number: ☐ Cell ☐ Work ☐ Home ☐ Other — *OK to leave messages?* ☐ Voice ☐ Text

Secondary phone: ☐ Cell ☐ Work ☐ Home ☐ Other — *OK to leave messages?* ☐ Voice ☐ Text

Enroll in MyChart online patient portal? ☐ Yes ☐ No

Ethnic Group *(check all that apply)*:
☐ Mexican, Mexican American, or Chicano/a
☐ Multiple Hispanic, Latino/a, or Spanish Origins
☐ Another Hispanic, Latino/a, or Spanish Origin
☐ Non-Hispanic or Latino/a
☐ Cuban
☐ Puerto Rican
☐ Choose not to disclose
☐ Unknown

Race *(check all that apply)*:
☐ African American / Black
☐ American Indian / Alaska Native
☐ Caucasian / White
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamarro
☐ Samoan
☐ Unknown
☐ Choose not to disclose
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Other: ____________

Patient's Insurance Information:

☐ Insured – Please present insurance card ☐ Uninsured

Is the patient the financially responsible person? ☐ Yes ☐ No *(If no, complete the information below. Do not complete for Medi-Cal/PHP minor patients.)*

Insurance Guarantor's Last Name	Insurance Guarantor's First Name	Middle Initial	Relationship to Patient

Address *(if different than patient address above)*

Best phone number for this person: ☐ Cell ☐ Work ☐ Home ☐ Other

Guarantor's Insurance Information

Insurance Company Name:

Insurance ID #/Member #:	Group #:

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Responsible Party | Additional Parent/ Legal Guardian/ Caregiver/ Conservator *(For patients under 18 or dependent adults.)*

Last Name	First Name	Middle Initial	Relationship to Patient
Address *(if different than patient address above)*			
City, State, ZIP			
Best phone number for this person: ☐ Cell ☐ Work ☐ Home ☐ Other		Does this person have rights to access the patient's account? ☐ Yes ☐ No *(If yes, ask for form.)*	

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 for this person: ☐ Cell ☐ Work ☐ Home ☐ Other		Does this person have rights to access the patient's account? ☐ Yes ☐ No *(If yes, ask for form.)*	

Primary Language ☐ English ☐ Spanish ☐ Other: ______________________

Dialect: ______________________________ **Do you need an interpreter for your visit?** ☐ Yes ☐ No

HouseholdIncome *(for grant purposes | FPL)*

Number of dependents including yourself? *(family size)*	Family monthly income before taxes?

Preferred Pharmacy

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

Medication Insurance *(if different than regular insurance)*

Disability/ Patient assistance needed *(check all that apply):*

☐ Other:

☐ None ☐ Low vision ☐ Hard of hearing ☐ Special needs ☐ Mobility ☐ Choose not to disclose

Veteran or Military status:

☐ Active duty ☐ Inactive duty ☐ No Experience ☐ Reservist ☐ Veteran

If you are a Veteran:

☐ Separated/ Combat Veteran?

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 what applies to you (*select one*):

- ☐ 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
- ☐ Neither

Check what applies to you (*select one):*

- ☐ 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: ______________________________
- ☐ Not Homeless

Consent to Treat *(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 receive.
- I know that receiving family planning services is not required to receive any other services offered by SRCH.
- 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 receive.

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