PEOPLE'S COMMUNITY CLINIC

PATIENT REGISTRATION FORM

☐ **PATIENT INFORMATION** ☐ **LEGAL GUARDIAN INFORMATION**

LAST NAME	FIRST NAME	MIDDLE NAME
SOCIAL SECURITY NUMBER	BIRTHDATE	SEX AT BIRTH ☐ MALE ☐ FEMALE
SEXUAL ORIENTATION: ☐ BISEXUAL ☐ LESBIAN OR GAY ☐ SOMETHING ELSE ☐ STRAIGHT ☐ DON'T KNOW ☐ CHOOSE NOT TO DISCLOSE		GENDER INDENTITY: ☐ MALE ☐ FEMALE ☐ OTHER ☐ TRANSGENDER MALE / FEMALE-TO-MALE ☐ TRANSGENDER FEMALE / MALE-TO-FEMALE ☐ CHOOSE NOT TO DISCLOSE
MAILING ADDRESS	APT NUMBER	COUNTY
CITY STATE ZIPCODE		LANGUAGE

YOU MAY RECEIVE APPOINTMENT REMINDERS VIA TEXT:

CELL PHONE	ALTERNATIVE PHONE	EMAIL ADDRESS
VETERAN: ☐ YES ☐ NO	HOMELESS: ☐ YES ☐ NO	MIGRANT WORKER: ☐ YES ☐ NO
MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED		ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ UNREPORTED / REFUSED TO REPORT

RACE:
☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ BLACK OR AFRICAN AMERICAN ☐ MORE THAN ONE RACE ☐ UNREPORTED / REFUSED TO REPORT
☐ WHITE

HOW DID YOU HEAR ABOUT PCC?
☐ FRIEND ☐ FAMILY MEMBER ☐ INSURANCE ☐ OTHER: _____
☐ HOSPITAL ☐ PROVIDER ☐ SCHOOL

SPOUSE OR PARTNER

LAST NAME	FIRST NAME	BIRTHDATE

FAMILY SIZE AND INCOME AS NOTED ON PROOF OF INCOME DOCUMENT(S)

FAMILY SIZE: _____

YEARLY INCOME: _____

FINANCIAL COUNSELOR SIGNATURE: _____

REFUSAL TO PROVIDE PROOF OF INCOME

PATIENT INITALS: _____

DATE: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME	RELATIONSHIP
EMERGENCY CONTACT PHONE NUMBER	

SIGNATURE

PATIENT OR AUTHORIZED SIGNATURE	DATE

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INCLUDE ALL CHILDREN		
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