SOUTHSIDE
Your Community Health Services

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Patient's Name (Last, First, MI):	Preferred Name:	Date of Birth: _____/_____/_____ MM / DD / YYYY
What sex were you assigned on your original birth certificate? (Check one): ☐ Male ☐ Female		SSN: __ __ __ / __ __ / __ __ __ __
Primary Language:	Do you need an Interpreter? ☐ Yes ☐ No	

Home Address: Apt #	City:	State:	Zip Code:

Preferred Phone (Check one): ☐ Home ☐ Cell ( )	Secondary Phone: ☐ Home ☐ Cell ( )	Email:

Marital Status (Check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Life Partner ☐ Widowed

DEMOGRAPHIC INFORMATION

As a federally funded community health clinic, we are required to collect certain demographics, all information is kept confidential.

Race (Select all that apply): ☐ Black/African American ☐ American Indian/Alaska Native ☐ White
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ Choose not to answer

Are you of Hispanic origin? ☐ Yes ☐ No ☐ Choose not to answer	If Hispanic, please check ethnicity origin: ☐ Mexican, Mexican American ☐ Puerto Rican ☐ Another Hispanic, Latino(a) or Spanish Origin ☐ Cuban ☐ Unknown ☐ Choose not to answer

Please mark if applicable: ☐ Experiencing homelessness	What is your country of origin?_____

Are you a (US) veteran? ☐ Yes ☐ No Are you an agriculture seasonal worker? ☐ Yes ☐ No Are you an agriculture migrant worker? ☐ Yes ☐ No	Household Size: _____ Estimated Yearly Household Income: $ _____ **You may qualify for a Sliding Fee Discount*

Do you identify as? (Check one):
☐ Straight or heterosexual
☐ Gay, lesbian, or homosexual
☐ Bisexual or pansexual
☐ Asexual or something else
☐ Questioning or don't know
☐ Choose not to answer

What are your pronouns?
☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:_____

To better serve you, what is your current gender identity? (Check one):
☐ Male
☐ Female
☐ Transgender Male/Trans Man/ Female-to-Male (FTM)
☐ Transgender Female/Trans Woman/ Male-to-Female (MTF)
☐ Additional Gender Category/Other please specify: _____
☐ Choose not to answer

EMERGENCY CONTACT INFORMATION

Name of Contact:	Phone Number of Contact:	Relationship:

PARENT / LEGAL GUARDIAN INFORMATION (if patient is a minor or not their own guardian)

Parent/Legal Guardian 1:
Relationship to patient: _____
Name _____
Phone ( )
☐ Legal Guardian DOB _____/_____/_____

Parent/Legal Guardian 2:
Relationship to patient: _____
Name _____
Phone ( )
☐ Legal Guardian DOB _____/_____/_____

Person Completing the form

_____	_____	_____
Printed Name	Signature	Date