



West Side

Community Health Services

PATIENT REGISTRATION FORM

PATIENT INFORMATION	Prefix	Last Name	First	MI	Birth Date
	Preferred Name <i>(If not the same as your legal name)</i>			Preferred Pronoun	SSN#
	Legal Guardian <i>(age 18 and younger)</i>				Birth Date
	Address	Apt	City	State	Zip
	Phone(s)	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other	
	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other:			
	Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hmong <input type="checkbox"/> Other:			
	Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	USA Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Gender Identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male from Female <input type="checkbox"/> Transgender Female from Male <input type="checkbox"/> Gender Queer <input type="checkbox"/> Other			
	Sexual Orientation	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian, gay or homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown <input type="checkbox"/> Other			
	Emergency Contact with Phone#			<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	

INSURANCE	<i>Please Present Receptionist With Your Insurance Card(s)</i>				
	Primary Insurance				
	Policy#			Group#	
	Policy Holder Name		DOB	SS#	

HOUSING	Do you live in Public Housing? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a seasonal migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are You Currently Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No		How long? _____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years		
	Where are you staying? <input type="checkbox"/> Friends / Family <input type="checkbox"/> Street <input type="checkbox"/> Shelter <input type="checkbox"/> Halfway Home <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other:				

RACE/ETHNICITY	Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	How do you identify yourself? <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Native American/Alaska Native Pacific Islander <input type="checkbox"/> Other:				
	Birth Country <i>(Where were you born?)</i> <input type="checkbox"/> El Salvador <input type="checkbox"/> Laos <input type="checkbox"/> Mexico <input type="checkbox"/> Thailand <input type="checkbox"/> USA <input type="checkbox"/> Other :				

