

PATIENT INFORMATION

Last Name _____ First _____ M.I. _____

Other Names _____ Preferred Name _____

Address _____

City _____ State _____ Zip Code _____

Cell phone #: (_____) _____ - _____ Alt. phone #: (_____) _____ - _____

Can we text you? Yes No Can we leave a voice message? Yes No

Date of Birth _____ / _____ / _____ Sex: Male Female Decline

Marital Status: Single Married Divorced Partner Widowed Legally Separated

Social Security Number _____ - _____ - _____

Employer Name _____

Employment Status: Full-Time Part-Time Not Employed Self Employed Retired
 Active Military Duty Unknown

Student: Full-Time Part-Time Not Student

Language Preference? English Spanish ASL Other

Email Address: _____ Mobile App Access: Yes No

RESPONSIBLE PARTY

(If patient is a minor -17 & younger - parent or guardian complete this section.)

Relationship to Patient: Self Parent Other _____

Last Name _____ First _____ M.I. _____

Custodial Responsibility: Self Parent Other _____

(Please provide custody forms & Photo ID.)

Date of Birth _____ / _____ / _____

Address _____

City _____ State _____ Zip Code _____

Cell phone #: (_____) _____ - _____

Alt. phone #: Home Work Cell (_____) _____ - _____

EMERGENCY CONTACT *(other than responsible party)*

Relationship to Patient: Parent Other _____

Last Name _____ First _____ M.I. _____

Cell phone #: (_____) _____ - _____

Alt. phone #: Home Work Cell (_____) _____ - _____

Patient Registration

Petaluma
Health Center
The Center of Good Health

Today's Date ____ / ____ / ____

PRIMARY INSURANCE INFORMATION

Relationship to Patient: Self Parent Other _____

Primary Medical Insurance _____ Policy Number _____

Insured Last Name _____ First _____ M.I. _____

Date of Birth of Insured ____ / ____ / ____ Insured SSN ____ - ____ - ____

Cell phone #: (____) _____ - _____

Alt. phone #: Home Work Cell (____) _____ - _____

SECONDARY INSURANCE INFORMATION

Relationship to Patient: Self Parent Other _____

Secondary Medical Insurance _____ Policy Number _____

Insured Last Name _____ First _____ M.I. _____

Date of Birth of Insured ____ / ____ / ____ Insured SSN ____ - ____ - ____

Cell phone #: (____) _____ - _____

Alt. phone #: Home Work Cell (____) _____ - _____

PHARMACY

PHC Pharmacy I'd like to use an outside pharmacy

Name of Pharmacy _____

Pharmacy Address _____

City _____ State _____ Zip Code _____

HOUSEHOLD INFORMATION

This information is very important for our funding as a Federally Qualified Health Center, and provides information that helps us better serve our patients and our community.

• Annual household gross income: \$ _____

Decline to State

• Number of children & adults dependent on this income: _____

Decline to State

• Your Race (*Please check one*): Asian Native Hawaiian Black/African American
 American Indian/Alaska Native Caucasian/White More than one race
 Choose not to disclose Other Pacific Islander Native Hawaiian

• Your Ethnicity (*Please check one*): Non-Hispanic Hispanic Choose not to disclose

• Are you a United States military veteran? Yes No

HOUSEHOLD INFORMATION *(continued)*

- In the past 2 years, have you or your financially dependent family members been a migrant worker in agriculture (temporarily move to another town to find work in agriculture like in vineyards or fruit picking)? Yes No
- In the past 2 years, have you or your dependent family members been a seasonal worker in agriculture (do not move from town to town to work, but only work certain seasons in agriculture like in vineyards or fruit picking)? Yes No
- I am: Lesbian or Gay Straight Bisexual Don't know
 Choose not to disclose Something Else _____
- Have you been homeless or in supportive housing at any time since January of this year?
 Yes No
Date you became homeless: ____ / ____ / ____
 Homeless Shelter Shared/Couch Surfing Street
 Transitional Housing Supportive Housing Other

HOW DID YOU HEAR ABOUT US?

- I'm a Current Patient Internet Radio Advertisement
- Another Patient/Friend Other