Patient Registration Form

Welcome to Share Ourselves!
We are happy you have chosen us for your care. To register, please fill out as much of this form as you can. Some of these items help us ensure we are meeting the needs of the people we serve. Please tell us if you have any questions, or if you need help filling out this form.

Legal Name

First: _____ Middle: _____ Last: _____

Preferred Name

First: _____ Middle: _____ Last: _____

Preferred pronouns:

☐ She/her/hers ☐ They/them/theirs ☐ He/him/his
☐ Use preferred name only ☐ Decline to answer ☐ Other:_____

Birth

Date of birth (month/day/year): _____ Age: _____

Social Security Number (if you have one): _____

Individual Taxpayer Identification Number (if you have one): _____

Sex assigned at birth: ☐ Female ☐ Male ☐ Unknown ☐ Intersex
☐ Choose not to say ☐ Not listed on birth certificate

Address

Street Address: _____ Unit/Space/Apt. #: _____

City: _____ State: _____ Zip Code: _____

Contact Information

Best phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐
Other_____

Share Ourselves

Can we leave messages?: ☐ Yes ☐ No

Other phone number: _____

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other _____

Preferred language: ☐ English ☐ Spanish ☐ Other

_____

Do you need translation help?: ☐ Yes ☐ No

How can we reach you? Choose all that apply:

☐ Telephone ☐ Text ☐ In writing ☐ Patient portal ☐ Email

If you choose **email** or **patient portal**, please list your email address:

_____

Marital Status

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Domestic partnership ☐ Significant other

Emergency Contact

For patients under 18, this must be different from the parent(s) or legal guardian(s) below.

First name: _____ Last name: _____

Relationship: _____ Phone number: _____

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

For Patients Under 18: Parent(s) or Legal Guardian(s)

☐ Mother ***or***

☐ Legal guardian 1

_____
Relationship

_____ _____
First name Last name

_____ _____
Date of birth Social Security Number or Individual Taxpayer Identification number

Street address: _____ Unit/Space/Apt. #: _____

City: _____ State: _____ Zip code: _____

Best phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

Other phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

☐ Father ***or***

☐ Legal guardian 2

_____
Relationship

_____ _____
First name Last name

_____ _____
Date of birth Social Security Number or Individual Taxpayer Identification number

Street address: _____ Unit/Space/Apt. #: _____

City: _____ State: _____ Zip code: _____

Best phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

Other phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

Because Share Ourselves is a Federally Qualified Health Center (FQHC), we must collect the information below. This helps us provide health care and sliding fee discounts to patients who qualify. We will keep your answers private.

Household Information

How many people live in your home?
(Include only yourself and family members you are financially responsible for.) _____

What is the total combined income of the family members included in the last question? _____
☐ Monthly ☐ Yearly

Would you like to know if you are eligible for our sliding fee discount program? ☐ Yes ☐ No

Insurance Information

Tell us about the patient's health insurance. Please provide the patient's insurance card at the time of check in.

Does the patient's or parent's employer offer medical or dental insurance?
☐ Yes ☐ No

Has the patient ever applied for any medical or dental insurance?
☐ Yes ☐ No

If yes, what has the patient applied for?
☐ Medi-Cal ☐ MSN
☐ Emergency Medi-Cal
☐ Medicare
☐ Other: _____

What insurance does the patient have now?
_____ Health plan name
_____ Member ID

Work Information

Work status:
☐ Full time ☐ Part time ☐ Full time student ☐ Part time student
☐ Unemployed ☐ Retired ☐Disabled ☐ Under 18

Job: _____

Does anyone in the home do farm work?
☐ Yes ☐ No

If yes, check all that apply:
☐ Migratory farm worker (moves to follow farm work)
☐ Seasonal farm worker (main job is farm work, but does not move to follow it)

Is the patient a veteran? ☐ Yes ☐ No

More Information

Gender Identity

☐ Female ☐ Male ☐ Transgender female (male to female)
☐ Transgender male (female to male) ☐ Choose not to say
☐ Other (specify): _____

Sexual Orientation

☐ Straight (heterosexual) ☐ Bisexual ☐ Gay ☐ Lesbian
☐ Pansexual ☐ Choose not to say
☐ Other (specify): _____

Ethnicity

☐ Cuban ☐ Mexican/Mexican-American/Chicano(a)
☐ Mulitple Hispanic/Latino(a)/Spanish Origins
☐ Non-Hispanic/Non-Latino(a) ☐ Puerto Rican
☐ Another Hispanic/Latino(a)/Spanish Origin ☐ Unknown
☐ Choose not to say

Race

☐ Alaskan Native ☐ American Indian ☐ Asian Indian
☐ Black/African American ☐ Chinese ☐ Filipino ☐ Korean
☐ Guamanian or Chamorro ☐ Japanese ☐ Native Hawaiian
☐ Other Asian ☐ Other Pacific Islander ☐ Vietnamese
☐ Samoan ☐ White ☐ Unknown ☐ Choose not to say
☐ Other (specify): _____

Highest Level of Education Completed

☐ Does not apply ☐ Did not complete high school
☐ High school ☐ Some college/Associate's degree
☐ Bachelor's degree or higher

Living Situation

☐ Homeless shelter ☐ Street ☐ Transitional housing
☐ Doubling up ☐ Permanent supportive housing
☐ Not homeless/not receiving assistance ☐ Other

How did you hear about us? Check all that apply.

☐ Insurance assigned me ☐ Community event/fair
☐ Family or friend ☐ Share Ourselves patient referral
☐ Hospital/doctor's office ☐ Share Ourselves employee
☐ El Sol Academy/student/family ☐ Automated phone invite
☐ Share Ourselves called me ☐ Ad ☐ Brochure ☐ 211
☐ Hoag Family Resource Center ☐ Social media
☐ Share Ourselves community event ☐ Yelp ☐ Google ad
☐ Share Ourselves website
☐ Other (specify):
_____