



Patient Registration Form

Please complete the following form to the best of your ability to register as a patient of Catherine's Health Center. Your responses will remain confidential along with your medical information. Ask our staff if you have any questions.

Legal Last Name, First Name, Middle Name _____ Today's date _____

First Name Used (if different than above): _____

Legal sex: Male Female Previous Name (if needed): _____

Date of birth _____ Social security number _____

Street Address:		City	State:	Zip:
Home Phone Number:	Cell Phone Number:	Is it okay to text this number? Y N Is it okay to send automated Y N calls to this number?		
Email address:				

Emergency Contact Name:	
Relationship:	Phone Number:

Name of next of kin (if same as emergency contact, please write "same") _____

Employment: None Employer Name: _____

Primary Language: English Spanish Other _____

Race: American Indian or Alaskan Native Asian White Black or African American Pacific Islander
 Native Hawaiian More than one race Decline to answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to answer

Relationship Status: Single Married Divorced Widowed Partner

Sexual Orientation: Lesbian Gay Straight/heterosexual Bisexual Unsure
 Choose not to disclose Other (please specify): _____

Gender Identity: Male (cisgender) Female (cisgender) Non-binary Transgender Male
 Transgender Female Choose not to disclose Other (please specify): _____

Sex assigned at birth: Male Female

Pronouns: he/him she/her they/them Other (please specify): _____

Are you:

Homebound? Yes No Decline to answer

An agricultural worker? Yes No Decline to answer

A patient of a school-based health center? Yes No Decline to answer

A veteran? Yes No Decline to answer

A public housing resident? Yes No Decline to answer

Do you own a house or are financially responsible for your current living arrangement Yes No
(i.e. pay rent, mortgage?)

If yes, do you have a standing legal agreement to reside at this location? Yes No

If no, please check any of the following boxes if they apply to your current living arrangement:

<input type="checkbox"/>	Staying with friends or family	<input type="checkbox"/>	Residing in a mobile vehicle
<input type="checkbox"/>	Living in transitional housing (shelter, halfway house, group home, etc)	<input type="checkbox"/>	Part of a housing program (Housing choice Voucher Program “Section 8,” Habitat for Humanity, etc.)
<input type="checkbox"/>	Living in a non-permanent accommodation (hotel, motel, hostel, etc.)	<input type="checkbox"/>	Living in poor conditions that would be considered uninhabitable (overcrowded, causing illness, etc.)
<input type="checkbox"/>	Experiencing homelessness	<input type="checkbox"/>	Decline to answer

Insurance Information (if you have insurance)

Insurance:	Subscriber’s Name:	Group #:	Policy #:
Insurance Phone Number:		Insurance Fax Number:	

How did you hear about us? Please check all that apply:

Advertising:

- Search Engine/Online Search
- Billboard
- Bus
- Online

Television

- Advertisement (Specify)

- News/Morning Show Segment
(Specify) _____

Outreach

- Event (Specify)

- Information Table (Specify
location)

- Community Organization
Referral (Specify):

Other

- Primary Care Physician
- Specialist Physician
- Word of Mouth
- Hospital
- Insurance Company
- Townline Elementary
- Crossroads Bible Church
- Other