Catherine's HEALTH CENTER

Patient Registration Form

Patient Information

Last Name:	First Name:	First Name Used:
Date of Birth:	Legal Sex: ☐ Male ☐ Female	Social Security Number:
Consent to Call: ☐ Yes ☐ No	Street Address:	
City:	State:	Zip Code:

Home Phone:	Cell Phone:	May we text you with information regarding your healthcare including appointment reminders? ☐ Yes ☐ No *Standard data/text rates may apply
Email Address:		

Emergency Contact Name:	Relationship:	Phone Number:
Next of Kin Name:	Relationship:	
Parent/Guardian Name (if under 18):	Parent/Guardian Phone Number:	

Demographics

Primary Language
☐ English
☐ Spanish
☐ Other:
☐ Decline to Answer

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

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

Sexual Orientation
☐Lesbian
☐Gay
☐Straight/heterosexual
☐Bisexual
☐Unsure
☐Decline to answer
☐ Other:

Gender Identity
☐Male Cisgender
☐Female Cisgender
☐Transgender Male
☐Transgender Female
☐Decline to answer
☐Other:

Agricultural Worker
☐ Yes
☐ No
☐ Decline to answer

Pronouns
☐He/him
☐She/her
☐They/them
☐Other: _____

Sex assigned at birth
☐Male
☐Female
☐Prefer not to disclose

Are you a Veteran?
☐ Yes
☐ No
☐ Decline to answer

Relationship Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Partner

Living/Housing Situation
☐ My own Home
☐ Staying with friends or family
☐ Non-permanent accommodation
☐ Experiencing homelessness
☐ A mobile vehicle
☐ Part of a housing program
☐ Transitional housing
☐ Decline to answer

Household Annual Income:
☐ None
☐ 0-$5,000
☐ $5,001- $10,000
☐ $10,001- $15,000
☐ $15,001- $20,000
☐ $20,001-$25,000
☐ $$25,001- $30,000
☐ $30,001- $35,000
☐ $35,001- $40,000
☐ $40,001- $45,000
☐ $45,001- $50,000
☐$50,001-$55,000
☐ $55,001-$60,000
☐ $60,001-$65,000
☐$65,001-$70,000
☐$70,001-$100,000
☐$100,001 or more
☐ Decline to Answer

Insurance Information

Insurance:	Subscriber's Name:
Group #	Policy #
Insurance Phone #	Insurance Fax #

Catherine's
HEALTH CENTER

Single Signature Page

I have read and/or received the following forms and policies. Copies are provided to patients upon request.

- Notice of Privacy Practice
- Patient Rights and Responsibilities
- FTCA Notice
- Financial Responsibility

Insurance Authorization and Assignment

I request that payment of authorized medical benefits is made on my behalf directly to Catherine's. I authorize to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Catherine's Health Center. I hereby authorize photocopies of this form to be valid as the original.

Consent to Treat

I authorize Catherine's Health Center and its medical, nursing, and other professional staff members to provide services. I authorize Catherine's professional staff members to administer such diagnostic and therapeutic procedures and treatment, as in the judgement of Catherine's medical personnel, deemed necessary or advisable in my care. I understand that all medical evaluation and treatment includes a degree of risk. I have the right to inquire about risks and benefits associated with recommended testing and treatment.

I understand that this Consent to Treatment is valid for each visit I make to Catherine's until revoked by me in writing. My signature below is my acknowledgement that I understand the forms, have read the forms and/or received a copy of the forms and policies listed above, and attest that the registration information I have provided to Catherine's Health Center is true and accurate to the best of my knowledge.

_____ _____

Patient or Parent/Legal Guardian if patient is a minor Date