Venice Family Clinic

REGISTRATION FORM *(Please Print)*

MR #_____

Legal Name of Patient: _____ **Birthdate:** _____/_____/_____
Last First Middle *Mo Day Yr*

Preferred Name: _____
First

Permanent Address: _____ **Social Security #** _____
Number Street Apt #

_____
City Zip Code

Home Phone: ( ) _____

Cell Phone: ( ) _____

Work Phone: ( ) _____

Preferred Number: _____

E-Mail: _____

Sexual Orientation:
☐ Lesbian or Gay
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't Know
☐ Choose not disclose

Gender at Birth: ☐ Male ☐ Female

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male (Female to Male)
☐ Transgender Female (Male to Female)
☐ Other
☐ Choose not to disclose

If Minor Relationship to Patient: ☐Parent ☐Foster Parent ☐Other Legal Guardian _____

Mother's Maiden Name: _____ **Father's Name:** _____

Emergency Contact: _____ **Phone:** _____
Name Relationship

RACE:
☐ Black/African American
☐ Asian
☐ American Indian/Alaskan Native
☐ White
☐ Declined to Report
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Multi-Race

LANGUAGE:
☐ English
☐ Spanish
☐ Russian
☐ Farsi
☐ Hindu
☐ Sign Language
☐ Other _____

MARITAL STATUS:
☐ Single
☐ Married
☐ Partner
☐ Widow
☐ Divorced
☐ Separated

INSURANCE
☐ Medicare - ☐HMO
☐ Medi-Cal - ☐HMO
☐ Healthy Families
☐ Healthy Kids
☐ No Insurance
☐ Other _____

ETHNICITY: **Hispanic/Latino Origin:** ☐YES ☐NO

How did you hear about our clinic? _____

NAMES OF IMMEDIATE FAMILY MEMBERS LIVING IN THE HOUSEHOLD	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOURCE OF INCOME	MONTHLY INCOME *(before taxes)*
1. **PATIENT**	**SELF**			**$**
2.				**$**
3.				**$**
4.				**$**
5.				**$**
6.				**$**
			TOTAL MONTHLY GROSS INCOME:	**$**

Venice Family Clinic

GENERAL CONSENT

I hereby request and consent to any diagnostic procedures, tests, and medical treatment deemed advisable by the professional staff of the Venice Family Clinic.

I further authorize the Venice Family Clinic to release medical/social information to persons or agencies directly concerned with public health or community welfare and to private individuals professionally engaged in carrying out a patient treatment plan.

I further authorize information to be released for the purpose of obtaining pharmaceuticals through the Patient Assistance Programs.

I further agree to notify the clinic/health center of any changes in my income, insurance or other factors used to determine my eligibility status.

I further agree to allow Venice Family Clinic verify my insurance eligibility and medication history when dispensing medications.

I HAVE READ THE CONSENT AND UNDERSTAND ITS CONTENTS. I ALSO CERTIFY THAT THE INFORMATION ON THE REGISTRATION FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ **DATE SIGNED:** ____/____/____

PATIENTS: DO NOT WRITE BELOW THIS LINE

NUMBER OF PEOPLE LIVING ON INCOME: _____

FPL: ____100% ____125% ____150% ____175% ____200% ____225% ____250% ____251% & Over

HOMELESS: Y N IF YES ---> ☐Shelter ☐Transitional ☐Doubling up ☐Street ☐Other ☐Unknown

PUBLIC HOUSING: Y N **TRANSLATOR NEEDED:** Yes ☐ No ☐

GENERAL RELIEF: Y N

SSI: Y N

WIC: Y N **Employment Status:** **Housing Status:** **Highest Education Completed:**

VETERAN: Y N ☐Full-Time ☐Own ☐Elementary

SCHOOL BASED H C: Y N ☐Part-Time ☐Rent ☐Middle School

SEASONAL FARM WORKER: Y N ☐ Not-employed ☐Other ☐High School

MIGRANT FARM WORKER: Y N ☐ Self-employed ☐ College

IF TEEN (12-18 yrs.) ☐ Retired ☐ Masters

Teen Consent Signed: Y N **Occupation/Employer**_____

Emancipated Teen: Y N **Confidential** **Yes** ☐ **No** ☐

DOCUMENTATION: **PATIENT ASKED FOR PROOF:**

1ST REQUEST PROOF OF ADDRESS _____ INCOME_____ _____/_____
DATE PT'S INITIALS

2ND REQUEST PROOF OF ADDRESS _____ INCOME_____ _____/_____
DATE PT'S INITIALS