axiscommunityhealth | PATIENT REGISTRATION

Patient First Name _____ *Patient Middle Name* _____ *Patient Last Name* _____

Date of Birth mm/dd/yyyy _____ *Preferred Name (optional)* _____ *Sex Assigned at Birth:* ☐ Male ☐ Female ☐ Choose not to disclose

Address, City, State, Zipcode _____ *Email Address* _____ *Cellphone Number* (with area code) _____ *Home phone Number* (with area code) _____

I PREFER TO BE CONTACTED BY:

☐ No Preference ☐ Mail ☐ Email ☐ Phone ☐ MyChart ☐ Do Not Contact

PATIENT'S EMERGENCY CONTACT:

Emergency Contact Name _____ *Emergency Contact Phone Number* (with area code) _____

Relationship to patient (spouse, parent, etc.) _____ ☐ Cell ☐ Home ☐ Other

LEGAL GUARDIAN INFORMATION

Are you the patient's legal guardian? ☐ Yes ☐ No

Do you have documents to prove it? ☐ Yes ☐ No

Name of legal guardian _____ *Date of Birth mm/dd/yyyy* _____

Relationship to patient (Parent, Legal Guardian, Other, etc.) _____

Have you served in the United States Military, armed forces or Unified Services? ☐ Yes ☐ No

PATIENT EMPLOYMENT STATUS

☐ Child ☐ Not Employed ☐ Part-Time ☐ Migrant or Seasonal Worker ☐ Student *(part-time)* ☐ Student *(full-time)* ☐ Full-Time ☐ On Active Military Duty ☐ Retired ☐ Self-Employed ☐ Unknown

PATIENT PREFERRED LANGUAGE

☐ Spanish ☐ English ☐ Cantonese ☐ Farsi ☐ Hmong ☐ Japanese ☐ Hindi ☐ Vietnamese ☐ Mandarin ☐ Punjabi ☐ Portugese ☐ Russian ☐ Tagalog ☐ Korean ☐ Urdu ☐ Other _____

Do you need a translator? ☐ Yes ☐ No

Do you have a disability? ☐ Yes ☐ No

PATIENT ETHNIC GROUP

☐ Another Hispanic, Latino or Spanish Origin ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican American, or Chicano ☐ Multiple Hispanic, Latino or Chicano ☐ Non-Hispanic or Latino/a ☐ Choose not to Disclose ☐ Don't Know

PATIENT RACE

☐ Alaska Native ☐ American Indian ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Chose Not to Disclose ☐ Don't Know

PATIENT MARITAL STATUS

☐ Divorced ☐ Legally separated ☐ Single ☐ Widowed ☐ Domestic Partnership ☐ Married ☐ Significant Other ☐ Unknown ☐ Other

HEALTH INSURANCE

Do you have insurance? Yes No

$ _____ *Monthly Gross income before taxes*

_____ *# of people in household including yourself*

HOUSING STATUS

☐ Homeless - Living temporarily with others
☐ At risk for homelessness
☐ Child at risk for homelessness
☐ Currently not homeless, but was in past 12 months
☐ Homeless unknown shelter
☐ Living in shelter
☐ Not homeless
☐ Permanent supportive housing
☐ Singe occupancy hotel
☐ Street, camp bridge
☐ Transitional housing
☐ Veteran at risk for homelessness

PATIENT SEXUAL ORIENTATION

☐ Straight ☐ Bisexual ☐ Lesbian or Gay ☐ Don't Know ☐ Other _____ ☐ Choose not to disclose

PATIENT GENDER IDENTITY

☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Other _____ ☐ Choose not to disclose

PREFERRED PRONOUNS

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other _____ ☐ Choose not to disclose

Patient/Guardian Signature _____ *If Guardian, Print Name* _____ *Date (mm/dd/yyyy)* _____

REV 8/2025