axiscommunityhealth | # PATIENT REGISTRATION

PATIENT INFORMATION

First Name:	Middle Name:	Last Name:
Preferred Name (optional):	Social Security Number:	Sex (at birth): ☐ Male ☐ Female
Date of Birth (mo/day/year):	Address:	Apartment #:
Zip Code:	City:	Cell Phone (with area code):
Home Phone (with area code):	Work Phone (with area code):	Email Address:

Please select your marital status:
☐ Divorced ☐ Legally Separated ☐ Other ☐ Single ☐ Widowed
☐ Domestic Partnership ☐ Married ☐ Significant Other ☐ Unknown

Please select your ethnic group:
☐ Non-Hispanic or Latino/a ☐ Another Hispanic, Latino/a or Spanish Origin ☐ Mexican, Mexican American, or Chicano/a ☐ Puerto Rican ☐ Unknown ☐ Choose not to disclose

Please select your race:
☐ Alaskan Native ☐ Black/African American ☐ Native Hawaiian ☐ Chinese ☐ Guamanian or Chamorro ☐ Caucasian
☐ American Indian ☐ Pacific Islander ☐ Filipino ☐ Japanese ☐ Patient Refused
☐ Asian Indian ☐ Samoan ☐ Other Asian ☐ Vietnamese ☐ Korean ☐ Unknown

I prefer to be contacted by (choose all that apply):
☐ No preference ☐ Mail ☐ Email
☐ Do not contact ☐ Phone ☐ MyChart

Have you served in the United States military, armed forces, or uniformed services? ☐ Yes ☐ No

Relationship to patient (spouse, parent, etc.):	Emergency Contact Name:	Emergency Contact Phone # (with area code): ☐ Home ☐ Work ☐ Cell

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

Did you bring the updated documents to prove you are the patient's legal guardian? ☐ Yes ☐ No

What is your employment status:
☐ Child ☐ Not employed ☐ Part-Time ☐ Seasonal ☐ Student (Part-Time) ☐ Unknown
☐ Full-Time ☐ On active military duty ☐ Retired ☐ Self-Employed ☐ Student (Full-Time)

Do you have a disability?
☐ Yes ☐ No If yes, what disability?:____________________

Do you need a translator? ☐ Yes ☐ No

Which is your preferred language?
☐ English ☐ Spanish ☐ Cantonese ☐ Farsi ☐ Hindi ☐ Hmong ☐ Japanese ☐ Korean
☐ Mandarin ☐ Punjabi ☐ Portuguese ☐ Russian ☐ Tagalog ☐ Urdu ☐ Vietnamese ☐ Other ____________

Do you have insurance? ☐ Yes ☐ No

For patients under 18, name of responsible person:

Relationship to patient: ☐ Parent ☐ Legal guardian ☐ Other ________

Parent/Guardian date of birth (mo/day/year): ____________________

Gross Income (before taxes): $____________ ☐ Per week ☐ Per month ☐ Per year

Number of people in household (include yourself): ______

Are you homeless? Yes ☐ No ☐

Are you living in public housing? ☐ Yes ☐ No

Are you a seasonal or migrant worker? ☐ Yes ☐ No

Do you think of yourself as:
☐ Lesbian or Gay
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't Know
☐ Choose not to disclose

How do you describe yourself:
☐ Female
☐ Male
☐ Transgender Female (Male to Female)
☐ Transgender Male (Female to Male)
☐ Non-binary/genderqueer
☐ Other
☐ Choose not to disclose

Please selct your preferred pronouns:
☐ She/Her/Hers
☐ He/Him/His
☐ They/Them/Theirs
☐ Patient's Name
☐ Decline to answer
☐ Unknown

______________________________ Patient/Guardian Signature

______________________________ If Guardian, Print Name

____________________ Date

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