DEPAUL COMMUNITY HEALTH CENTERS

REGISTRATION FORM

(Please Print)

Today's Date:	Provider:

PATIENT INFORMATION

Last Name:	First Name:	MI:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Preferred Pharmacy:

Social Security #:	Birth Date:	Marital Status:		
	/ /	❑ Single ❑ Married	❑ Divorced ❑ Separated	❑ Partnered ❑ Widowed

❑ Parent Name ❑ Guardian Name	Birth Date:	Phone if Different from Patient:
	/ /	

Street Address or P.O. Box:		State:	ZIP Code:

Email Address:	Home Phone No.:	Cell Phone No.:
	( )	( )

Occupation:	Employer:	Employer Phone No.:
		( )

During the past year, what was the total combined income for you and the family members you live with?	How many people, including you, are currently in your household?
$	

Preferred Contact Instructions:		What language are you most comfortable speaking?		Do you have an Advanced Directive?
❑ Phone ❑ Email ❑ Mail	❑ Text ❑ Do not contact ❑ Other: _____	❑ English ❑ Spanish ❑ Arabic	❑ Portuguese ❑ Other: _____	❑ Yes (please provide a copy for your medical record) ❑ No

Race:			Highest level of school:
❑ Black or African American ❑ White ❑ American Indian or Alaska Native ❑ Native Hawaiian ❑ Samoan ❑ Guamanian or Chamorro	❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese	❑ Other Asian: _____ ❑ Other Pacific Islander: _____	❑ Elementary ❑ Some high school ❑ High school diploma or GED ❑ Some college or technical school ❑ Bachelor's degree ❑ Any post graduate studies

Do you consider yourself to be:	Gender Identity:	Sex Assigned at Birth:	Preferred Gender Pronoun:
❑ Straight or heterosexual ❑ Lesbian, gay or homosexual ❑ Bisexual ❑ Don't know ❑ Something else:_____	❑ Male ❑ Female ❑ Transgender Female (Male to Female) ❑ Transgender Male (Female to Male) ❑ Do not identify as male, female or transgender	❑ Male ❑ Female	❑ He/him ❑ She/her ❑ They/them

Veteran Status:	Housing Status:		Agricultural / Migrant Worker?
❑ Veteran ❑ Non-Veteran	❑ Stable/Permanent Housing ❑ Rent Home ❑ Own Home ❑ Public Housing	❑ Homeless ❑ Transitional Housing ❑ Doubling up ❑ Live on the Street ❑ Unknown	❑ Yes ❑ No

DePaul Community Health Centers

How hard it is it for you to pay for the very basics (food, housing, medical care)?	Was there a time in the past 12 months when you did not take your medications as prescribed because of cost?
❑ Very hard ❑ Somewhat hard ❑ Not hard at all	❑ Yes ❑ No

How do you *usually* get to medical appointments?

- ❑ Drive myself
- ❑ Get a ride from family or friends
- ❑ Take bus or street car
- ❑ Walk
- ❑ Bicycle
- ❑ Ride in service agency van
- ❑ Taxi
- ❑ Other: _____

Are you a registered voter?

❑ Yes ❑ No

Referred to clinic by (please check one box):

- ❑ Friend
- ❑ Family
- ❑ Doctor: _____
- ❑ Close to home/work
- ❑ Hospital: _____
- ❑ Yellow Pages
- ❑ Insurance Plan
- ❑ Web Search
- ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:			Policy Number:	Group Number:
Insured's Last Name:	**First Name:**	**MI:**	**Insured's S.S. #:**	**Insured's Date of Birth:**
				/ /
Patient's relationship to insured:	❑ Self ❑ Spouse ❑ Child ❑ Other			**Co-payment: $**
Secondary Insurance:			**Policy Number:**	**Group Number:**
Insured's Last Name:	**First Name:**	**MI:**	**Insured's S.S. #:**	**Insured's Date of Birth:**
				/ /
Patient's relationship to insured:	❑ Self ❑ Spouse ❑ Child ❑ Other			**Co-payment: $**

EMERGENCY CONTACT INFORMATION

Name of local friend or relative (not living at same address):	Relationship to patient:
Home Phone No.:	**Work Phone No.:**

☐ **The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DePaul Community Health Centers or the insurance company to release any information required to process my claims. This authorization shall remain valid until I, revoking said authorization, give written notice.**

☐ **I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of DePaul Community Health Centers.**

☐ **I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.**

Patient / Guardian Name (Print):

Patient / Guardian Signature:	***Date:***

Relationship to Patient: