ST. CROIX REGIONAL FAMILY HEALTH CENTER
PATIENT REGISTRATION FORM

Name:
LAST FIRST M.I.

Mailing Address:

Physical Address:

City:

State:

Zip:

Home Phone:
( ) -

Cell Phone:
( ) -

Work Phone/Extension:
( ) -

Best Phone to Leave Message:
☐Home ☐Cell ☐Work
☐Any ☐None

Best Time to Leave Message:
☐Morning ☐Noon
☐Evening

E-mail Address:

Social Security #:
- -

Birth Date:
/ /

Gender:
☐Male
☐Female

Gender Identity:
☐Male ☐Female
Transgender:
☐Male/Female to Male ☐Female/Male to Female

Sexual Orientation:
☐Straight ☐Lesbian/Gay
☐Bisexual ☐Something else
☐Don't know ☐Choose not to disclose

Responsible Party:

Relation:

Phone:
( ) -

Emergency Contact:

Relation:

Phone:
( ) -

Primary Care Provider (if not SCRFHC):

Marital Status:
☐Single ☐Married
☐Divorced ☐Widowed
☐Legally Separated

Race:
☐American Indian/Alaskan Native ☐Asian
☐Black/African American
☐Native Hawaiian ☐Pacific Islander
☐White

Language:

Ethnicity:
☐Hispanic ☐Non-Hispanic

Employment Status:
☐Employed ☐Unemployed ☐Retired
☐Self-Employed ☐Active Duty
☐Disabled

Employer Name: _____
Employer Address: _____
Employer Phone: ( ) -

☐Migrant Worker
☐Seasonal Worker

Student Status:
☐Full-time ☐Part-time ☐N/A

Veteran:
☐Yes ☐No

Transportation:
☐Self ☐Family/Friend ☐Public

Primary Insurance Name:

ID #:

Group #:

Secondary Insurance Name:

ID #:

Group #:

Primary <u>Dental</u> Insurance Name:

ID #:

Group #:

Secondary <u>Dental</u> Insurance Name:

ID #:

Group #:

Name of Dentist:

Name of Pharmacy:

Family Size:

Income:
☐ 0 - 20,000 ☐ 21,000 – 40,000 ☐ 41,000 – 60,000 ☐ 61,000 – 80,000 ☐ 81,000 - over

Treatment Consent, Release of Information, RX History Consent

I give my permission to St. Croix Regional Family Health Center to render diagnostic procedures, minor surgical and medical treatment. To request and release medical/dental relevant information to other providers as is determine necessary in the course of treatment to me, or the above named dependent.

I request that payment of authorized insurance benefits be made on my behalf to SCRFHC for any services furnished to me by that provider. I authorize any holder of medical information, including prescription history, about me to be released to the insurance company and its agents to determine these benefits or the benefits payable for related services.

Signature:

Date: