PATIENT/CLIENT REGISTRATION FORM

Today's Date:_____

Last Name	**First Name**	**Middle Name**
Other names used	**Date of Birth**	
Social Security Number	**Birth Sex** ☐ Male ☐ Female ☐ Decline to answer	

Current Gender

☐ Male ☐ Female ☐ Transgender

☐ Decline to answer

Sexual Orientation

☐ Straight or heterosexual

☐ Lesbian, gay, or homosexual ☐ Bisexual

☐ Other ☐ Decline to answer

☐ Don't know ☐ Unknown

Gender Identity

☐ Male ☐ Female

☐ Transgender Man/ Male

☐ Transgender Woman/Female

☐ Other

☐ Choose not to disclose

☐ Unknown

Preferred Pronouns

☐ He/Him/His ☐ She/Her/Hers

☐ They/Them/Theirs ☐ Ze/Hir

☐ Other: Specify_____ ☐ Decline to Answer

Physical Address

Street Address

City State Zip Code

Mailing Address (check here if same as above) ☐

Street or P.O. Box

City State Zip Code

Contact Information	
Home Phone	Cell Phone ☐ OK to leave a message ☐ Ok to send text messages
Alternate Phone	☐ OK to leave a message ☐ Do not leave a message
Email	

Emergency Contact (Let us know who to call if there's an emergency.**)**

Name Phone Relationship

Preferred Language

☐ English ☐ Spanish ☐ Dari ☐ Farsi ☐ Russian ☐ Vietnamese

☐ Chinese ☐ Pashto ☐ Punjabi ☐ Other_____

Marital Status

☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed

☐ Other_____

Are you a student?

☐ No ☐ Yes, full-time ☐ Yes, part-time

Have you ever served in the United States Military?

☐ No ☐ Yes

Have you experienced homelessness at any time since January of this year?

☐ No

☐ Yes, doubling up/couch surfing ☐ Yes, shelter ☐ Yes, on the street ☐ Yes, transitional housing

☐ Yes, other: _____ ☐ Unknown

Race: (check one)

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ Black/African American
☐ American Indian
☐ White
☐ More than one race
☐ Choose not to disclose race

Ethnicity: (check one)

☐ Mexican, Mexican American Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a, or Spanish Origin Combined
☐ Hispanic, Latino/a, or Spanish Origin
☐ Not Hispanic
☐ Choose not to disclose Ethnicity

Agricultural Worker? In the past 2 years, have you or a family member worked in any type of agriculture (farm work), like working with cows/chickens/horses/pigs, planting crops, picking crops, packing house, or driving a truck with produce?

☐ No ☐ Yes

Are you Head of Household? This information will help WellSpace Health identify additional programs to help communities. This information also helps us identify patients and clients who may qualify for specialty funded programs or services they were unaware they qualified for.

☐ Yes, Self ☐ No, Other Person _____ _____ # of persons in your family _____

Family income $_____ ☐ Annually ☐ Monthly ☐ Weekly

Would you like assistance during your appointment?

☐ No, thank you ☐ Yes, language interpreter ☐ Yes, low vision/blindness ☐ Yes, mobility assistance

☐ Yes, Other_____

_____

Patient/Client Signature (or Parent/Guardian of Patient Signature) **Date**

Patient/Client Consent to Treatment

- By signing below, I consent to receive medical, dental, and/or behavioral health services from WellSpace Health either in person or via telehealth, including immunizations (or am consenting for the minor in my care).
- I understand WellSpace Health provides clinical training opportunities to students or Residents who may be involved in my care.
- I authorize WellSpace Health to contact me via cell phone, email, or text regarding upcoming appointments and/or preventive health care screenings.
- I acknowledge my responsibility to pay for services according to the policies established by WellSpace Health.
- If I have private health insurance, I understand I have the right to opt out of using my health insurance for services provided. If I do opt to use my health insurance, I acknowledge that I am responsible for paying the full amount for services rendered.
- I authorize the assignment of benefits for services to be paid to WellSpace Health.
- The information I have given is true to the best of my knowledge.

_____

Patient/Client Name **Date of Birth**

_____

Patient/Client Signature (or Parent/Guardian of Patient Signature)

_____

Today's Date