CLIENT REGISTRATION WORKSHEET

Today's Date ___/____/_____

Client Name: First _______________________ Middle________________________

Last ___________________________**Student ID Number**____________________

Preferred Name or "Nickname"____

Other Names/Aliases ____

Client Social Security Number (optional): _________-________-____________

Sex: ◻Female ◻Male ◻Other____________ **Date of Birth** (mm/dd/yy):___/___/___

Address ____

City________________________________**State**______**Zip Code**:_____________

Home Phone____________________May we call you at this number? ◻ Yes ◻ No

Mobile/Cell Phone_______________May we call you at this number? ◻ Yes ◻ No

Email Address (Optional)___________________________________

Language: Do you need an interpreter? ◻ Yes ◻ No If Yes, what is your primary language? _________________________________

Housing Status

Have you been in safe and stable housing for the past year? ◻ Yes ◻ No

If "No": ◻ Transitional housing ◻ Living with others ◻Shelter ◻ Street/Camp/Bridge

◻ Other, describe:____

Do you live in a public housing complex?: ◻ Yes ◻ No ◻ Not sure or Decline to answer

Migrant or Seasonal worker? ◻ No ◻ Migrant Worker ◻ Seasonal Worker

Veteran Status: Have you ever served in the US Military? ◻ Yes ◻ No

Ethnicity: ◻ Hispanic/Latino ◻ Non-Hispanic/Latino ◻ Decline to answer

Race Please check all that apply: ◻ Asian ◻Alaskan Native ◻ American Indian ◻ Black or African American ◻ Pacific Islander ◻ Hawaiian Native ◻ White ◻Decline to answer

Primary Care Provider: Do you have a current Primary Care Provider: ◻ Yes ◻ No

If yes, who is your provider? ___________________________

Citizenship Information

ALIEN ID: __________Country of Origin:______Date of Entry (mm/dd/yy):___/___/___

NOT TO BE FILED INTO CLIENT'S HEALTH RECORD

What services are you here for today?

□ Dental □ Family Planning □ Primary Care □ Motor Vehicle Accident
□ Workers Compensation □ WIC/Maternity Support Services

Insurance Information

Do you have any type of medical or dental insurance coverage?

□ **Yes** (please show your medical insurance card at check-in) □ **No**

If yes, please check all that apply: □Medicaid/ProviderOne □Take Charge

□Healthy Options □Medicare □Basic Health Plan □BHP Plus □CHIP

□Commercial Insurance □Other________________________

Insurance/Plan ____

Group/Policy Number____

Subscriber's Name____

Subscriber's Birth Date____

Subscriber's Relationship to patient: Parent/Guardian, Patient__________

Emergency Contact

Emergency Contact Name:____

Relationship:____________________________ Legal Guardian: □ Yes □ No

Phone#_______________________ Alternate Phone#________________________

Do Not Complete the information below if you are an adolescent (13 -17 years) requesting confidential services.

Parent/Guardian Information – (Required for clients under 18 years of age)

Last Name		First Name	Relationship to client	
Phone	May we call you at this number? □ Yes □ No	Alternate phone	May we call you at this number? □ Yes □ No	
Address (if different from client)		City	State	Zip

Other Parent/Guardian Information – (If Applicable)

Last Name		First Name	Relationship to client	
Phone	May we call you at this number? □ Yes □ No	Alternate phone	May we call you at this number? □ Yes □ No	
Address (if different from client)		City	State	Zip