MORONGO BASIN COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

# PATIENT/CLIENT REGISTRATION FORM

**Today's date:**________________________________

| **Last Name** | **First Name** | **Middle Name** |
|---|---|---|
| **Preferred names used** | **Date of Birth** | |
| **Social Security Number** | **Preferred Pharmacy** ______________________________ | |

**Current Gender**
☐ Male ☐ Female ☐ Non-Binary
☐ Decline to specify

**Gender Identity**
☐ Male ☐ Female ☐ Non-Binary ☐ Decline to specify

**Sexual Orientation**
☐ Straight or heterosexual
☐ Lesbian, gay, or homosexual
☐ Bisexual
☐ Something else
☐ Don't know
☐ Decline to specify

**Preferred Pronoun**
☐He/Him/His ☐She/Her/Hers ☐They/Them/Their
☐Other ☐Decline to specify

**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 ☐Ok to leave message ☐ Do not leave message

Cell Phone ☐Ok to leave message ☐ Do not leave message

Email: (check here if OK to use this email to enroll in Patient Portal) ☐

**Language**

☐ American Sign ☐Chinese ☐English ☐Hmong ☐Japanese ☐Punjabi ☐Spanish ☐Russian
☐ Tagalog ☐Vietnamese ☐Other______________________________

**Religion**

☐ Buddhist ☐ Catholic ☐ Christian ☐ Eastern Orthodox ☐ Hindu ☐ Islamic ☐ Jehovah's Witness
☐ Mormon ☐ Unitarian ☐ None ☐ Other______________________________

**Type of Insurance** ☐ Medicare ☐ Medi-Cal ☐ IEHP ☐ Private ☐ No Insurance

**Marital Status**

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

Other ______________________________

**Are you a student?**

☐ No ☐ Yes

**Are you a veteran?**

☐ No ☐ Yes

**Are you a migrant worker?**

☐ No, not a farm worker ☐ Yes, Migrant ☐ Yes, Seasonal worker

**Have you been homeless 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: ______________________________

**Racial Background** (check all that apply)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White

☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to specify

☐ More than one race ______________________________

**Are you Hispanic or Latino?**

☐ No ☐ Yes

**Are you experiencing food insecurity?**

☐ No ☐ Yes

**If yes, do you need food today?**

☐ No ☐ Yes

**Are you Head of Household?**

☐ Yes, Self ☐ No, Other Person ______________________________

# of persons in your family ______________ (include self, spouse/significant other, dependent child under the age of 18)

Family income $______________ ☐ Annually ☐ Monthly

**Emergency Contact**

Name

Phone

Relationship

**Would you like assistance during your appointment?**

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

☐ Yes, Other ______________________________

**Patient/Client Agreement**

- The information I have given is true to the best of my knowledge.
- By signing below, I am consenting to receiving medical, dental, and/or behavioral health services from Morongo Basin Community Healthcare either in person or via telehealth, including immunizations (or am consenting for the minor in my care).
- I acknowledge Morongo Basin Community Healthcare provides clinical training opportunities to students who may be present during my visit.
- I acknowledge my responsibility to pay for services according to the policies established by Morongo Basin Community Healthcare.
- I authorize assignment of benefits for services to be paid to Morongo Basin Community Healthcare.

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