DATE: _____ El Centro de Corazón Quality Health Care MRN: _____

# Patient Registration Form

**Patient's Full Name** (First name – Middle name – Last names)

_____

**Date of Birth:** _____

**Country of Origin:** _____

**Social Security Number:** _____

**Preferred Name (if any):** _____

**Legal Guardian's Name:** _____
(If applicable or if patient is a minor)

**Main phone number:** _____ ☐ Home ☐ Cell

**Secondary phone number:** _____ ☐ Home ☐Cell

**Email:** _____

**Home Address:**

_____

_____

*(Street number and name, APT number, City, State, Zip code, County)*

*El Centro De Corazón* sends appointment/communication reminders via text message. By checking this box, **I DO NOT WANT** any text communication (opt out) ☐

**Preferred contact method:** *El Centro De Corazón* may use any of the methods below when necessary to contact you.
☐Phone ☐Letter/Post Mail ☐Email ☐MyChart

**Homeless?** ☐No ☐At Risk ☐Yes ☐Living with others
☐ Living in shelter

**Civil Status?** ☐Single ☐Married ☐Domestic Partner ☐Divorced
☐ Other: _____

**Gender? (assigned at birth)** ☐Male ☐Female

**Race (if multiracial, choose all that apply)**:
☐ White ☐Black/Afroamerican ☐American Indian ☐Asian Indian
☐ Other Asian: _____ ☐Refuse to answer

**Ethnicity:** ☐Mexican, Mexican/American, Chicano ☐Honduran
☐ Puerto Rican ☐Salvadoran ☐Cuban ☐Multiple Hispanic
☐ Non-Hispanic ☐Other Hispanic: _____

**Preferred Language:** ☐English ☐Spanish ☐Other: _____
**Need an interpreter in your preferred language?** ☐Yes ☐No

**Are you a U.S Veteran?** ☐Yes ☐No

## Emergency Contact

**Name:** _____

**Relationship with patient:** _____

**Phone Number:** _____

## Guarantor Name (Person responsible for payments)

☐ Myself (Patient) ☐Someone Else (if someone else, provide their information below)

**Name:** _____

**DOB:** _____ **Relationship:** _____

**Phone number:** _____

**Home Address:** _____

**Household size?** _____ ☐ **Yearly**

**Total household income?** $_____ ☐**Monthly**

## Patient's Employment Information

**Employment type:** ☐Full Time ☐Part Time ☐Student
☐ Migrant/Seasonal ☐Agricultural Worker ☐Unemployed

**Employer/Company Name:** _____

**Profession/Occupation:** _____

**Does anyone in your household have Medicaid, Medicare, Chip, V.A, or other health coverage?** ☐No ☐Yes
If yes, who? _____

**Have you applied in the last 30 days?** ☐No ☐Yes

## Health Insurance

**Insurance Type:** ☐None/Self-Pay ☐Private Insurance ☐Medicare
☐ Medicaid/TWHP/CHIP/CHIP Perinatal ☐Tricare ☐Other

**Insurance name:** _____

**Subscriber's Name:** _____

**Subscriber's DOB / Relationship to Patient:** _____

**Member ID:** _____

**How did you hear about El Centro De Corazon?** ☐Family ☐Friend
☐ Drive/Walk By ☐Flyer ☐TV/Radio ☐School ☐External Referral
☐ Community Event ☐Internet/Online search

For patients 18 years and older, please respond the following questions:

1. **Sexual orientation:** term used to describe which gender(s) someone is sexually and/or romantically attracted to
2. **Gender identity:** how we feel and express our gender and gender roles: clothing, behavior, and personal appearance. It's a feeling we have as early as the age of two or three.

**Sexual Orientation:** ☐Heterosexual ☐Bisexual ☐Other
☐Homosexual/Gay/Lesbian ☐Not sure ☐Refused to disclose
**Current Gender Identity:** ☐Male ☐Female ☐Transgender Female
☐ Transgender Male ☐Refuse to disclose
**Preferred Pronouns:** ☐She/Her ☐He/Him ☐They/Them ☐Other
☐My Name ☐Unknown ☐Refused to disclose