TRI-CITY HealthCenter

Our Community. Your Health.

REGISTRATION FORM MR#: ______

*Please print all information

PATIENT INFORMATION

Do you consider yourself to be Homeless? Yes ☐ No ☐

Last Name: ______ First Name: ______ M. Initial: ______

Birthdate: ______ Social Security#: ______ Sex: M ☐ F ☐ Veteran: Yes ☐ No ☐

Home Address: ______ City: ______ Zip Code: ______

Home Phone: ______ Cell Phone: ______ Work Phone: ______

Email Address: ______ Specify preferred contact method Such as Home Phone, Cell Phone, Work Phone, or Email ______

Interpreter Needed: Yes ☐ No ☐ If yes, language? ______ Is the patient a minor, (<18): Yes ☐ No ☐

Marital Status: ______ Mother's Maiden Name: ______

EMPLOYMENT

Employer: ______ Employer Address: ______

Employer Phone: ______ Occupation: ______

MONTLY INCOME

Is the patient the Head of the Household? Yes ☐ No ☐ Head of Household Name: ______

Monthly Income: $ ______ Family Size: ______ Head of Household's Birthday: ______

ETHNICITY

- ☐ Afghani
- ☐ African_
- ☐ American
- ☐ Asian
- ☐ East Indian
- ☐ European
- ☐ Hawaiian Native
- ☐ Filipino
- ☐ Hispanic / Latino
- ☐ Indochinese
- ☐ Middle Eastern
- ☐ Native American
- ☐ Pakistani
- ☐ Pacific Islander
- ☐ Undeclared
- ☐ Other / Specify Below:

____

____

RACE

- ☐ White
- ☐ Asian
- ☐ African American
- ☐ Native American
- ☐ Black
- ☐ Alaska Native
- ☐ Pacific Islander
- ☐ Undeclared
- ☐ Other / Specify Below:

____

____

EMERGENCY CONTACT

First Name: ______ Primary Phone: ______

How did you hear about us? ______

Form last updated: 11/21/14