La Clínica
a californiahealth+ center

PO Box 22210 • Oakland, CA 94623
www.laclinica.org

PATIENT I.D. CARD
PATIENT NAME _____
MR# _____ DOB _____ M F
PRIMARY PROVIDER _____ DATE _____

❑ La Clínica de La Raza ❑ San Antonio Neighborhood Health Center
❑ Clínica Alta Vista ❑ La Clínica Oakley ❑ La Clínica Pittsburg
❑ La Clínica Monument ❑ La Clínica Vallejo ❑ La Clínica North Vallejo
❑ La Clínica Vallejo Great Beginnings ❑ Davis Pediatrics

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Legal Last Name: _____ Legal First Name: _____ MI _____

Date of Birth: _____/_____/_____ Sex at birth: ☐ Male ☐ Female Social Security Number: _____ - _____ - _____

Mailing Address: _____ City: _____ Zip: _____

Preferred Name (Alias): _____ E-mail: _____

Communication Preference: ☐ Mail ☐ Text ☐ Call ☐ E-Mail (same as above) ☐ My-Chart

Text: Please provide Cell phone number (_____) _____ - _____, Is it okay to send text message to this Cell number? ☐ Yes ☐ No

Call: Please provide Telephone number (_____) _____ - _____, Is it okay to leave a message on this Telephone number? ☐ Yes ☐ No

If different e-mail, please provide: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Legally Seperated ☐ Significant Other

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic ☐ Patient Refused ☐ Unknown

Race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black / African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unknown ☐ Patient Refused

United States Veteran / Military Status: ☐ Active Duty ☐ Inactive Duty ☐ No Previous Experience ☐ Reservist ☐ Veteran

Emergency Contact:

Full Name: _____ Relationship: _____

Emergency Contact Telephone Number: (_____) _____ - _____

Patient / Legal Guardian #1 (If 17 yrs and under):

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Phone Number: (_____) _____ - _____ Date of Birth: ____/____/_____

Address (if different): _____ City: _____ State: _____ Zip: _____

Patient / Legal Guardian #2 (If 17 yrs and under):

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Phone Number: (_____) _____ - _____ Date of Birth: ____/____/_____

Address (if different): _____ City: _____ State: _____ Zip: _____

Patient Employer Name: _____

Employment Status: ☐ Child ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Active Military Duty ☐ Self-Employed
☐ Active Military Duty ☐ Self-Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Disabled

Interpreter needed? ☐ Yes ☐ No **Preferred Language**: _____ **Visually or hearing impaired**: _____

INSURANCE INFORMATION

_____ / _____ _____ / _____
Medicare Member Full Name | Medicare Member ID | Medi-Cal Member Name | Medi-Cal Member ID

_____ _____ _____ _____/_____/_____
Other Health Plan Name | Member Name | Insurance ID# | DOB

Assignment Of Benefits & Financial agreement: I authorize payment for all medical benefits to La Clinica for professional service rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collection and reasonable attorney fees.

Patient / Guardian Signature: _____ Date: _____

ADDITIONAL PATIENT INFORMATION (please answer all questions)

La Clinica is a non-profit organization committed to serving the needs of our community. This information will help La Clinica access additional grants to continue helping our uninsured and underserved residents in our communities. This information also helps us identify clients who may qualify for specialty funded programs or services they were unaware they qualified for. This information will become a part of your confidential medical record.

Family Size (including patient)? _____ **What is your Annual Income (before taxes) $**_____

Has the patient been homeless in the last 12 months? ☐ Yes ☐ No

If yes, ☐ Homeless Shelter ☐ Doubling Up ☐ On Street ☐ Public Housing ☐ Other: _____

Patient's Gender Identity: ☐ Female ☐ Male ☐ Trans (MTF) ☐ Trans (FTM) ☐ Decline ☐ Non-Binary / Genderqueer ☐ Other

Patient's Sexual Orientation:

☐ Straight or Heterosexual ☐ Bi-Sexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Something Else

☐ Do Not Know ☐ Decline ☐ Non-Binary / Queer ☐ Omnisexual ☐ Asexual

Patient's Pronoun:

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Their ☐ Ze/Hir/Hirs ☐ Ey/Em/Eirs ☐ Xe/Xem/Xyrs ☐ Other ☐ Patient's Name ☐ Decline to answer ☐ Unknown

Consent: To provide treatment, bill your insurance, or other administrative tasks required by your insurance carrier, we must receive your consent by providing your signature below.

NOTICE OF PRIVACY PRACTICES: La Clínica is committed to protecting your health information in compliance with the law. The attached Notice of privacy practice states:

- That it is our obligation under the law to protect your information with respect to your personal health information.
- How we may use and disclose health information.
- Your rights related to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The Conditions that apply to users and disclosures not described in this Notice.
- The contact information to get further information about our privacy practices.

I, hereby, acknowledge that I have received /been offered a copy of the Consent and Notice of Privacy Practices.

Patient / Guardian Signed: _____ Date: _____

Parent / Patient's Representative Full Name: _____ Date: _____

Important Document Request:

* Please provide at least one document for each category listed below.

- ► For Children: Ages 17 and under: Birth Certificate or Guardianship Power of Attorney.
- ► Identification: Photo ID or Driver License or any unexpired Identification.
- ► Proof of Residency Status: Work Permit, Residency Card (Green Card), Citizenship Certificate or American passport.
- ► Proof of Income: Last Months Pay Stub, Income Tax Declaration, W-2 Form
- ► Proof of address: Utility Bill or rent bill.
- ► Other: Social Security Card
- ► Other: Insurance Card