La Clínica
a california health+ center

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

PATIENT I.D. CARD
PATIENT NAME ______________________
MR# ____________ DOB ____________ M F
PRIMARY PROVIDER ______________ DATE ________

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

Legal Last Name: ____________________ Legal First Name: ____________________ MI: ________

Preferred Name *(Alias)*: ______________________________ Date of Birth: ______/_____/________

Sex Assigned at Birth: ❒ Female ❒ Male ❒ Not Disclosed

Legal Gender (as shown on Government ID): ❒ Female ❒ Male

Primary Residence or Mailing Address: ______________________________________

City: ______________________________ Zip: ______________

Homeless Status: ❒ Yes ❒ No

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated

Communication Preference:

❒ **Primary number**: Cell phone number (_____) _______ - _______. Is it okay to send text / call to this Cell #? **YES / NO**

❒ **E-mail:** ______________________________. Is it okay to e-mail you on this E-mail? **YES / NO**

❒ **My-Chart:** Is a secure online portal where you can view and manage your medical information. Do you want to sign up? **YES / NO**

Interpreter needed? ❒ YES ❒ NO **Preferred Language:** ______________ Visually or hearing impaired: ______________

Public Housing: ❒ YES ❒ NO

Ethnic Group: ❒ Another Hispanic, Latino/a or Spanish Origin ❒ Mexican, Mexican American, or Chicano/a ❒ Non-Hispanic or Latino/a ❒ Patient Refused / Chose not to disclose ❒ More than One Ethnicity

Race: ❒ Alaskan Native ❒ American Indian ❒ Asian Indian ❒ Black / African American ❒ Guamanian or Chamorro ❒ Native Hawaiian ❒ Other Asian ❒ White *(Blanco)* ❒ Patient Refused / Chose not to disclose

United States Veteran / Military Status: ❒ Yes ❒ No

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

Emergency Contact: Full Name: ______________________________________

Relationship: ____________________ Emergency Contact Telephone Number: (________) __________ - ____________

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

Last Name: ______________________________ First Name: ____________________ MI: ________

Relationship to the Patient: ______________ Phone Number Cell: (_____) ______ - ________ DOB: ______/_____/________

Address *(If different)*: ____________________ City: ______________ State: __________ ZIP: __________

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

Last Name: ______________________________ First Name: ____________________ MI: ________

Relationship to the Patient: ______________ Phone Number Cell: (_____) ______ - ________ DOB: ______/_____/________

Address *(If different)*: ____________________ City: ______________ State: __________ ZIP: __________

Household Size and Income Information: This information is mandatory to participate in sliding fee discount program.
Other People in the family Include: Spouse, domestic partner, minor children & Tax filing dependents

	First Middle Last Name	DOB	Legal Gender or Gender at Birth	Relationship to You	La Clínica Current Patient?
1			❒ Female ❒ Male		❒ Yes ❒ No
2			❒ Female ❒ Male		❒ Yes ❒ No
3			❒ Female ❒ Male		❒ Yes ❒ No
4			❒ Female ❒ Male		❒ Yes ❒ No
5			❒ Female ❒ Male		❒ Yes ❒ No

Is there a pregnancy in this household? ❒ Yes

Are there more than 6 people in your household? ❒ Yes (Use an additional page to add them)

Enter how much money you and / or the people named above earn. Please bring proof of income to your next visit.

Income Type	Income Total $	How Often
❒ **Employment / Self Employment**	$__________________	❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Yearly
❒ **Unemployment or State Disability**	$__________________	❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Yearly
❒ **Pension / Social Security Benefits**	$__________________	❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Yearly
❒ **Other**	$__________________	❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Yearly
Are you applying for the Sliding fee Discount program? ❒ Yes ❒ No		

For Staff Use Only:			
Verified Status: ❒ Verified - Have shown Proof of listed income	Effective Date:____/____/____ Expiration Date:____/____/____	HH size: ________ FPL% ______ Discount Category: ❒ A ❒ B ❒C ❒ D ❒ E NOT Eligible for Sliding Fee [ ]	**Staff Print Name:** ____________ **Staff Initial:** ______________

Consent for Treatment: The undersigned patient and/or responsible Guardian hereby authorizes La Clínica de La Raza, any and all service sites, its affiliated providers to administer and perform any and all medical examinations, treatments, diagnostic and surgical procedures or other services which may now or during the course of the patient's care be deemed advisable or necessary. The patient has the right to stop and/or refuse treatment or service any time during a visit.

➔ Patient / Guardian Signature: ____ Date: ____________________

I, hereby, acknowledge that all the information I have provided on this form is true and accurate to the best of my knowledge.

➔ Patient / Guardian Signed: ____ Date: ____________________

➔ Parent / Patient's Representative Full Name: ____________________________________ Date: ____________________

Name of staff person: ________________________________ Title:________________ Date Processed: _____/_____/_____

Social Determinants of Health (SDH):

- Within the past 12 months, you worried that your food would run out before you got money to buy more?
  ❒ Often True ❒ Sometimes True ❒ Never True ❒ Declined
- Within the past 12 months, the food bought just didn't last and you didn't have money to buy more?
  ❒ Often True ❒ Sometimes True ❒ Never True ❒ Declined
- Would you like assistance with any of the above items? ❒ YES ❒ NO