CRCHC Patient Registration Form

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Separated ☐ Widow

Primary Language ☐ English ☐ Spanish ☐ Other ________________ Do you need an interpreter? ☐ Yes ☐ No

Patient Full Legal Name:	Date of Birth:	Social Security:	
If the patient is a minor, legal guardian name:		Referred By:	
Street Address:			
City:	State:	Zip Code:	County:
E-Mail: *Are you interested in registering for the patient portal?* ☐ *Yes* ☐ *No*	Home Phone #	Cell Phone # Consent to text ☐ Yes ☐ No	
If unable to reach me: ☐ You may leave a detailed message ☐ Leave a message asking me to call back			

Race: (Select all that apply)	Sexual Orientation	Where do you live?
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/African American ☐ White /Caucasian ☐ Native Hawaiian ☐ Other ☐ Other Pacific Islander ☐ More than one race ☐ Choose not to disclose Ethnicity: ☐ Hispanic or Latino/a ☐ Non-Hispanic or Latino/a Preferred Pharmacy: Name ______________________ Location ___________________ ___________________________	☐ Straight *(not lesbian or gay)* ☐ Lesbian or Gay ☐ Bisexual ☐ Don't Know ☐ Other (asexual, pansexual, etc.) ☐ Choose not to disclose Gender ☐ Male ☐ Female ☐ Transgender Female *(male to female)* ☐ Transgender male *(female to male)* ☐ Other ☐ Choose not to disclose Assigned sex at birth: ☐ Female ☐ Male ☐ Choose not to disclose Seasonal Migrant Worker? ☐ Yes ☐ No Are you a veteran? ☐ Yes ☐ No	☐ Rent or own Home/Apartment ☐ Public Housing ☐ Shelter Name:__________________ ☐ Street/Car ☐ Doubling up (*staying with family or friends*) ☐ Transitional *(live place to place)* ☐ Other _____________ Number of People in Household: Adults _______ Kids _______ Household Income Range: ☐ Less than $12,000 ☐ $12,000 – $20,000 ☐ $20,000-$40,000 ☐ $40,000-$60,000 ☐ More than $60,000

Patient Signature *(or guardian)* ______________________________ Date ___________________________