Unicare Community Health Center Patient Registration

UCHC/Pt. Reg., May 2020

Patient Name: _____
Last First Middle

Address: _____
Street Apt. # City Zip

Phone #: ( ) _____ ( ) _____ ( ) _____
Home Work Cellular

Do you have a **Social Security Number?** ☐ Yes ☐ No Social Security Number: _____

Is your Social Security # for employment only? ☐ Yes ☐ No Email Address: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female
Month / Day / Year

Homeless? ☐ Yes ☐ No

Living Situation: ☐ Own ☐ Rent ☐ Motel/Hotel ☐ Car/Vehicle ☐ Halfway House/Shelter ☐ Homeless Shelter ☐ Transitional ☐ Street ☐ Permanent Supportive Housing ☐ Other

Are you a Veteran? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Are you disabled? ☐ Yes ☐ No

Smoke? ☐ Yes ☐ No

Sexual orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Do not wish to disclose

Ethnicity: ☐ Non-Latino/ Hispanic ☐ Latino/ Hispanic

Race: ☐ White ☐ Asian ☐ African American ☐ American Indian ☐ Pacific Islander ☐ Native Hawaiian ☐ More than 1 race ☐ Refuse to report

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Do not wish to disclose

Education level completed: ☐ Less than high school graduate ☐ High school graduate ☐ Some College/Associate degree ☐ Bachelor's degree or higher

Are you an agricultural worker? ☐ Yes ☐ No

If yes, are you seasonal or migrant? ☐ Seasonal ☐ Migrant

Is one of your family members an agricultural worker? ☐ Yes ☐ No

If yes, which type? ☐ Seasonal ☐ Migrant

Number of people in your family household: _____ **Annual family income:** $ _____

What language should your information be provided in? _____

How well do you understand English? ☐ Very well ☐ Moderate ☐ Very little ☐ None

Do you have any allergies? _____

Friend or Relative to Contact In Case of Emergency: _____ ( )
(Name) (Relationship) (Telephone #)

If minor, mother's name: _____ If minor, father's name: _____

How did you hear of the Clinic UCHC? _____

1. Do you have health insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____

2. Do you have dental insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____

3. Do you have Medi-Cal? ☐ Yes ☐ No Have you applied? ☐ Yes ☐ No Policy #: _____

4. Does your child (patient) have CHDP? ☐ Yes ☐ No **5.** Do you have FPACT? ☐ Yes ☐ No

I understand that health information is confidential. I authorize the exchange of information between UCHC and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available upon request. I authorize to receive any and all services provided by UCHC, including but not limited to: Primary Care, Dental, Behavioral, Substance Use and Psychiatric services.

I hereby authorize treatment by UCHC. ☐ Yes ☐ No Initials _____

The exchange of information may include treatment for:

Alcohol or drugs- ☐ Yes ☐ No Initials _____ Psychiatric drugs- ☐ Yes ☐ No Initials _____

Adequate numbers of radiographs are required for proper diagnosis.
I consent to performing radiographs as needed for my dental treatment: ☐ Yes ☐ No Initials _____

Patient Signature or guardian (if minor): _____ **Date** _____

Name and relationship (if not patient) _____