English

Yearly Patient Registration

Today's Date: _______/_______/_______

Gender Identity:			**Sexual Orientation:**		
☐ Male ☐ Female ☐ Other	☐ Transgender If Yes: ☐ Decline	☐ Female to Male ☐ Male to Female	☐ Straight **(not lesbian/gay)** ☐ Bisexual	☐ Lesbian/Gay ☐ Something Else	☐ Choose not to Disclose ☐ Don't Know

First Name: ______________________ Middle Initial: _________ Last Name: _________________________

Mailing Address: ___________________________ City: ____________ State: _____ Zip Code: ___________

DOB: _________/__________/_________ Social Security Number: __________-__________-____________

Home Phone: (_____) _____-______ Cell phone: (_____) ______-_____ Work Phone: (_____) _____-______

Preferred Time to Call: ☐ Morning ☐ Afternoon Best way to Contact: ☐ Voice ☐ Email ☐ Portal

Email: ______________________________ Enroll in our Patient Portal? ☐ Yes ☐ No ☐ Already Enrolled

Information about Patient:

Gross Annual Income: ☐ $0 - $20,000 ☐ $20,000 - $30,000 ☐ $30,000 - $40,000 ☐ $40,000 +

Family Size: _______ Are Homeless? ☐ Yes ☐ No

If Yes: ☐ Shelter ☐ Street Campground ☐ Transitional Housing ☐ Doubling up (Family or Friend)

Marital Status:

☐ Single ☐ Married

☐ Separated ☐ Single w/ Partner

☐ Divorced ☐ Widow

More Information:

Are you a Student? (Part Time Or Full Time?) ☐Yes ☐No

Are you a Veteran? ☐Yes ☐No

Are you a Seasonal worker? (Lives here full-time) ☐Yes ☐No

Are you a Migrant worker? (Lives here part-time) ☐Yes ☐No

Ethnicity/Race: (check all that apply)

☐ Hispanic/Latino ☐ Native American ☐ White ☐ Asian ☐ Native Hawaiian

☐ Pacific Islanders ☐ Refuse to answer ☐ African American ☐ Alaskan Native ☐ Other:______________

Primary Insurance:

☐ Partnership ☐ Medicare ☐ Medi-Cal ☐ Covered California ☐ Other Insurance: ____________________

Subscriber ID Number: ____________________________________

☐ No Insurance

Emergency Contact:

Name: ________________________ Relationship: ______________ Telephone: (________) _________-__________

Please Turn Page

TREATMENT CONDITIONS:

Consent to Treatment: The undersigned hereby consent to the administration and performance of all diagnostic procedures and treatment, which, in the judgment of the physician assistant/nurse practitioner/ dentist may be considered necessary.

Medicare Assignment: I certify that the information given to me in applying or payment under Title VII of the Social Security Act is correct. I request that payment of the authorized benefits be made in my behalf.

Assignment of Insurance Benefits: In the event I am entitled to benefits arising out of any policy of insurance insuring me or any party liable to me. I hereby assign said benefits directly to Anderson Valley Health Center for application to my bill. I agree that Anderson Valley Health Center may issue a receipt for any such payment, that payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for changes not covered by the agreement.

Patient's Signature: ____ Date: _______/________/________

☐ Parent ☐ Guardian (specify relationship):_______________________ Date: _______/________/________