Patient Registration – Serve the People Community Health Center

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As a Federally Qualified Health Center, we strive to provide quality and accessible care to all our patients. In order for us to make such informed decisions, we must gather the following information. Please understand that you have the option not to respond. This information will not affect your eligibility to any services with Serve the People Community Health Center (STP CHC)

Today's Date:	**Date of Birth:**	**How did you hear about STP?** Social Media / School Event / Community Event / STP Food Pantry / Other:
Last Name:	**Sex Assigned at birth:** (Male) (Female)	
First Name:	**Middle Name:**	**Marital Status:** (circle your answer)
Address:	**Sexual Orientation:** (circle your answer)	Divorced / Married / Partner / Single / Widowed / Legally Separated
City:	Lesbian or Gay / Heterosexual / Bisexual / Don't know / Choose not to disclose / Other:	**Preferred Language:** (circle your answer)
State: **Zip:**		English / Spanish / Other:
Home phone #:	**Gender Identity:** (circle your answer)	**Race:** (circle your answers)
Cell phone #:	Male / Transgender Male / Choose not to disclose / Female / Transgender Female / Other:	Asian Indian / Vietnamese / Filipino / Chinese / Japanese / Korean / Other Pacific Islander / Black / African American / Guamanian or Chamorro / Other Asian / Native Hawaiian / Samoan / White / American Indian / Alaskan Native / Choose not to disclose
E-mail:	**Parent / Guardian information:**	
Personal Income: (circle your answer)	Name:	**Ethnicity:** (circle your answers)
Earned (non-agricultural) / General Public Assistance / *agriculture / Veteran / Retirement / Disabled / None / Other:	Phone #:	*Hispanic, Latino/a or Spanish Origin / Not Hispanic, Latino/a, or Spanish Origin / Choose not to disclose
* = prepare, water, or spray fields, nurseries, orchards; plant, collect, sort, pack, or transport agricultural products; work on farms that produce / handle livestock	Relation to Patient:	*if you circled Hispanic, please specify:
Housing Status (circle your answer)	**Emergency Contact:**	Mexican / Mexican American / Chicano / Another Spanish Culture or Origin / Puerto Rican / Cuban
I have housing / Shelter / Street / Transitional housing / Permanent Supportive housing / Doubled up (unable to maintain housing & stay with a series of friends / family)	Name:	
Other:	Phone #:	
	Relation to Patient:	
	If you do not have insurance, are you interested in obtaining help to see if you quality for medical and/or dental insurance? (YES) (NO)	

Do you have **medical insurance?** (YES) (NO)		Do you have **dental insurance?** (YES) (NO)	
If yes, Medical Insurance name:		If yes, Dental Insurance name:	
Subscriber name:		Subscriber name:	
Date of birth:	ID#:	Date of birth:	ID#:

I understand that I am the financially responsible party for all charges (deductible, co-ins, etc.) for services rendered to me, including the balance remaining after payment of possible insurance benefits. I hereby agree, consent, and authorize STP CHC, any and all physicians, physician's assistants, nurse practitioners, paraprofessionals including medical students, residents, interns and/or its employees to order or conduct any and all medical / dental / psychological / diagnostic / radiological studies, and treatment, dispense medication or any and all other treatment, which they consider necessary and / or advisable for my physical, dental, and mental condition.

Signature (parent or guardian if minor)		Relation to patient:		**Date:**