

# 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  Some College/Associate degree  
 High school graduate  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?        | <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES, with what company are you insured? _____   |
| 2. Do you have dental insurance?        | <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES, with what company are you insured? _____   |
| 3. Do you have Medi-Cal?                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Policy #: _____ |
| 4. Does your child (patient) have CHDP? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Do you have FPACT? <input type="checkbox"/> Yes <input type="checkbox"/> 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.  Yes  No Initials \_\_\_\_\_  
 I consent to performing radiographs as needed for my dental treatment: \_\_\_\_\_

**Patient Signature or guardian (if minor):** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name and relationship (if not patient)** \_\_\_\_\_