UNICARE COMMUNITY HEALTH CENTER, INC.

PATIENT REGISTRATION FORM

PATIENT INFORMATION (please print)

Last Name	**First Name**	**MI**	**Date of Birth**

Address	**Apt./ Unit**	**City**	**State**	**Zip Code**

SSN _ _ _ - _ _ - _ _ _ _	**ID/ Driver's License Number**	**Birth Sex** ☐ M ☐ F	**Email Address**

Please check primary phone ☐ Home Phone ( ) ☐ Cell Phone ( ) ☐ Work Phone ( )

Primary Language ☐ English ☐ Spanish ☐ Other:

Do you need an interpreter? ☐ Yes ☐ No

Race (check all that apply)

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ White
☐ American Indian/ Alaska Native
☐ Black/ African American
☐ More than one race
☐ Unreported/ Choose not to disclose

Ethnicity

☐ Mexican/ Mexican American/ Chicano
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a, or Spanish origin
☐ Non-Hispanic, Latino/a, or Spanish origin
☐ Unreported/ Choose not to disclose

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

Sexual Orientation ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Other ☐ Don't know ☐ Choose not to disclose ☐ Unknown

Gender Identity ☐ Male ☐ Female ☐ Transgender Male (F - M) ☐ Transgender Female (M - F) ☐ Other ☐ Choose not to disclose ☐ Unknown

Health Insurance ☐ Medicare ☐ Medi-Cal ☐ None ☐ Other (please specify):

Are you an Agricultural Worker? ☐ Yes ☐ No
If yes, was this: ☐ Migratory ☐ Seasonal

Is one of your family members an Agricultural Worker?
☐ Yes ☐ No ***If yes, was this:*** ☐ Migratory ☐ Seasonal

Are you a Veteran of the United States Armed Forces? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

If you are homeless, please indicate your living arrangement (check one):

☐ Homeless Shelter (safe havens, temporary overnight housing)
☐ Doubling Up (living with other people temporarily, move often)
☐ Permanent Supportive Housing (rent, no time limits)
☐ Unknown
☐ Transitional (center, community, home)
☐ Street (sidewalk, car, park, doorway, abandoned building)
☐ Other (hotel, motel, day-to-day single room occupancy)

SPOUSE OR PARENT/LEGAL GUARDIAN INFORMATION (if applicable)

Last Name	**First Name**	**Relation to Patient**	**Date of Birth**

Please check primary phone ☐ Home Phone ( ) ☐ Cell Phone ( ) ☐ Work Phone ( )

Rev. 07/2023

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EMERGENCY CONTACT			
Last Name	**First Name**	**Relation to Patient**	**Date of Birth**

Please check primary phone ☐ Home Phone ( ) ☐ Cell Phone ( ) ☐ Work Phone ( )

SLIDING FEE SCALE DISCOUNT PROGRAM

Unicare Community Health Center provides comprehensive and high-quality primary care services to persons in need, regardless of their ability to pay. At Unicare, you will not be turned away even if you do not have health insurance. Sliding Fee is a program that may offer you a discount on your medical, dental and behavioral health charges. The program sets a discount on what you pay based on the size of your family and annual income.

Household Size:_____ Household Annual Income: $_____ ☐ Decline

Would you like to apply for the Sliding Fee Scale Program? ☐ Yes ☐ No

PHARMACY

Name of Preferred Pharmacy: _____ Phone Number: ( )
Pharmacy Address: _____

CONSENT TO RECEIVE TELEPHONE CALLS AND SMS MESSAGES

I consent to receive telephone calls and/or SMS messages (including text messages) from Unicare Community Health Center, or others communicating on Unicare's behalf at the specific number(s) I have provided. As part of this consent, I represent and warrant the following:

(1) I am the owner or authorized user of the mobile phone number(s) identified below. I will notify Unicare immediately if I am no longer the owner or authorized user of the mobile phone number(s) identified below.
(2) Unicare or others communicating on their behalf may call and/or send SMS messages in various formats and with various contents, including but not limited to phone calls and/or SMS messages about upcoming appointments.
(3) I am solely responsible for any phone call charges and/or message and data charges associated with such phone calls and/or SMS messages.
(4) I may opt-out of receiving these communications at any time by calling my Unicare clinic. Please allow 2-3 business days for processing.

Printed Name: _____ Signature: _____

Phone Number: ( ) Alternate Phone Number: ( )

☐ I DO NOT consent to receive telephone calls and/or SMS messages (including text messages) from Unicare Community Health Center. I understand that my experience with the service(s) that rely on communications via phone calls and/or SMS messages (including text messages) may be impacted.

CONSENT TO USE THE PATIENT PORTAL/HEALOW

Unicare Community Health Center offers secure viewing and communication via your computer, cell phone, or tablet, as a service to patients who wish to view portions of their medical record and communicate with our staff and health care providers. The Patient Portal, Healow, is designed to improve provider and patient communication. Please note that all communication via Healow will be included in your permanent patient record. Once you are registered as a patient and have provided us with your secure email address, you will receive an email with a link to register.

After you are registered with Healow, you will be able to:

- update your contact information
- view your laboratory results
- view your medical summary, medication list, treatment history, and visitation dates

The following will not be accepted through Healow:

- requesting appointments
- requesting any medications and/or prescription refills
- requests for narcotics/controlled medications
- requesting advice on the best course of treatment for your medical problem(s). All diagnoses will be made by your provider when you are seen for an office visit

Please select only one (check box):

☐ I hereby consent to use the Patient Portal/Healow. I understand that upon registering to use Healow, I will receive a copy of the privacy and security risks and measures which will require my acceptance in order to proceed.

☐ I DO NOT consent to use the Patient Portal/Healow.

PATIENT/PARENT/LEGAL GUARDIAN ATTESTATION

I attest that I have completed this form truthfully and to the best of my knowledge.

Patient/Parent/Legal Guardian Signature: _____ **Date:** _____

Name and Relationship (if not patient): _____

FOR OFFICE USE ONLY	
Registering Patient Service Rep:	Patient MRN: