JEFFERSON COMPREHENSIVE HEALTH CENTER
PATIENT ANNUAL REGISTRATION FORM

PATIENT INFORMATION (Photo ID is required)

NAME FIRST	MI	LAST	PATIENT ID#

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

HOME PHONE	SOCIAL SECURITY NUMBER	SEX/GENDER ○FEMALE ○ MALE	DATE OF BIRTH

LANGUAGE ○English ○ Spanish ○ French ○ Arabic Would you like an interpreter? ○ No ○ Yes	EDUCATION - Highest Grade Completed ○ Elementary ○ High School ○ College ○ Post/Secondary /Graduate School	MARTIAL STATUS ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated ○ Partner

RACE and ETHNICITY (Check both 1 and 2): 1. ○ Black/African American ○ Asian ○ American Indian/Alaska native ○ White ○ Native Hawaiian ○ Other Pacific Islander ○ More than 1 race	2. ○ Not Hispanic/Latino ○ Hispanic/Latino	AGRICULTURAL WORKER: ○ Seasonal ○ Migrant ○ Not Applicable
HOUSING: ○ Permanent resident ○ Shelter ○ Transitional ○ Doubling up ○ Street ○ Other	DISABLED ○ No ○ Yes, Date________	VETERAN ○ No ○ Yes
EMERGENCY CONTACT: NAME	PHONE	RELATIONSHIP
EMPLOYMENT/STUDENT ○ Full Time Student ○ Part Time Student ○ Full Time ○ Part Time ○ Unemployed ○Self-employed ○ Military Active Duty ○ Retired, Date__________________	WORK PHONE	CELL PHONE

EMPLOYER NAME	EMPLOYER ADDRESS	CITY	STATE	ZIP

Income of patients at this Heath Center is a Federal reporting requirement. Thank you for providing this information.

TOTAL ANNUAL INCOME:	NUMBER OF PEOPLE IN YOUR HOUSEHOLD:

RESPONSIBLE PARTY INFORMATION (PARENT, GUARDIAN, Guarantor – Complete if applicable)

NAME FIRST	MI	LAST	RELATION TO PATIENT:
STREET ADDRESS	CITY	STATE	ZIP

STREET ADDRESS	CITY	STATE	ZIP	PHONE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX/GENDER ○ FEMALE ○ MALE

INSURANCE INFORMATION (Medicaid, Medicare, Private insurance card is required)

○ NO INSURANCE	○ MEDICAID, ID #
○ PRIVATE INSURANCE Complete Information below	○ MEDICARE ID# Do you have an insurance that covers you before Medicare? ○ No ○ Yes, please specify:

PRIMARY INSURANCE:	COPAY $	**SECONDARY INSURANCE:**	COPAY $
Following information is not required when insurance card is provided			
GROUP/POLICY#	ID#	GROUP/POLICY#	ID#

Your visit today is covered by: ○ Workman’s compensation ○ Liability Insurance ○ Not applicable

I hereby certify that the information shown above is correct.

SIGNED:	DATE:	WITNESS:	DATE: