PATIENT REGISTRATION FORM

VALLEY Family Health Care

Valley Family Health Care (VFHC) is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act. We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.

PATIENT INFORMATION

Name: First	Middle	Last
Preferred Name:	**SSN:**	**DOB:** / /

Birth Gender: ☐Male ☐Female	**Sexual Orientation**: ☐Straight ☐Lesbian ☐Bisexual ☐Gay ☐Unknown ☐Other ☐Choose not to disclose	**How would you like to be referred to?** ☐He/Him/His ☐She/Her/Hers ☐They/Them/Theirs ☐Choose not to disclose ☐Other:

Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:

Preferred Phone:	**Are text messages, ok?** ☐Yes ☐No	**We may contact you by phone, text, or email with updates about your care—like appointments, billing, prescriptions, health info, provider or clinic changes, the patient portal, or occasional marketing. Please let us know how you prefer to be contacted.**
Would you like access to the Patient Portal? ☐Yes ☐No	**How would you like your invitation?** ☐Email ☐Text	
Email:		

PCP Name & Phone**:**

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Partner ☐Other/Unknown

As a Federally Qualified Health Center, we are **REQUIRED** to collect the following information to help us improve care and lower costs for all. Your personal information is **NOT SHARED**. **Please help us by answering the following questions below.**

Ethnicity	☐Another Hispanic, Latino/a, or Spanish Origin	☐Cuban	☐Multiple Hispanic, Latino/a, or Spanish Origins		
	☐Mexican, Mexican American, or Chicano/a	☐Non-Hispanic or Latino/a	☐Puerto Rican	☐Unknown	
Race	☐Alaskan Native	☐American Indian	☐Asian Indian	☐Black/African American	☐Chinese
	☐Filipino	☐Guamanian or Chamorro	☐Japanese	☐Korean	☐Native Hawaiian	☐Other Asian
	☐Other Pacific Islander	☐Samoan	☐Unknown	☐Vietnamese	☐White

Please check one option:	☐Employed ☐Self-Employed ☐Unemployed ☐Retired ☐Disabled ☐Child ☐Seasonal
Employer Name:	**Employer Phone:**
What is your preferred language? ☐English ☐Spanish ☐Other-specify:	**Do you need an interpreter?** ☐Yes ☐No
Veterans	Are you a Veteran? ☐Yes ☐No
Living Status	☐Own/Rent ☐Homeless Shelter ☐Transitional ☐Doubling Up ☐Street ☐Unknown ☐Other:
Farmworkers	**In the past two years**, have you or a member of your family worked in agriculture (fields, orchards, etc.) as the primary source of income? ☐Yes ☐No
	If yes, does this person change residence as part of their work? ☐Yes ☐No

RESPONSIBLE PARTY (LEGAL AND/OR FINANCIAL)

Responsible Party's Name First**:**	Middle	Last	
☐Self ☐Parent/Guardian	☐Other:	DOB: / /	
Email:	Phone:		
Address:	City:	State:	Zip:
Employer:	Employer Phone:		
Do you have Medical/Dental Insurance? ☐Yes ☐No	If yes, Insurance Carrier Name:		

REDUCED FEES

Family Income	Our annual household income before taxes is $_____. There are **#**_____ people in my household (including myself). ☐Choose not to disclose
Are you interested in applying for our reduced fees (**even if you are insured**)? ☐No ☐Yes *(proof of income will be requested)*	

EMERGENCY CONTACT INFORMATION

Name:	
Phone:	Relationship to Patient:

Print Name and Relationship of the person filling out this form:	
Patient/Legal Guardian Signature:	Date:

We comply with applicable Federal civil rights laws and do not discriminate based on race, color, ethnicity, citizenship status, national origin, gender, gender identity, sexual orientation, age disability, religion, or any protected status protected.