DESERT SENITA
COMMUNITY HEALTH CENTER
Quality, Local, Affordable Health Care for All

Patient Registration Form

Patient Information: *Last Name* | *First Name* | *Social Security No.*

Physical Address | *City* | *State* | *Zip* | *County*

Mailing Address | *City* | *State* | *Zip* | *County*

Home Phone | *Work Phone* | *Email Address* | *Date of Birth*

Household Size | **Head of Household Name** | **Income Level** ☐ Monthly ☐ Annual

Primary Insurance | **ID #** | **Group #** | **Name of Insured Party**

Responsible Party: *Last Name* | *First Name* | *Social Security No.*

Physical Address | *City* | *State* | *Zip* | *County*

Mailing Address | *City* | *State* | *Zip* | *County*

Home Phone | *Work Phone* | *Email Address* | *Date of Birth*

Employer Name | *Employer Address*

Relationship to Responsible Party
☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Marital Status
☐ Single ☐ Married ☐ Divorced

Primary Language

Race
☐ Asian
☐ American Indian/Alaska Native
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ White

Are you Hispanic/Latino? ☐ YES ☐ NO

Are you a veteran? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

Some of the following questions may be uncomfortable for you to answer; however, your honest responses will assist Desert Senita in providing the best services for you as an individual. By answering the following questions, you will help us to qualify the resources that support the services we provide for you.

Sexual Orientation:
☐ Lesbian/Gay/Homosexual
☐ Straight/Heterosexual
☐ Bisexual
☐ Something Else/Other
☐ Don't Know/Questioning
☐ Choose Not To Disclose

Gender Identity:
☐ Male
☐ Female
☐ Other/Gender Variant/Inter-sex
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Choose Not To Disclose

Sex Assigned At Birth:
☐ Male
☐ Female
☐ Choose Not To Disclose

What pronoun do you prefer to be addressed by? ☐ She/Her ☐ He/Him ☐ They ☐ Zie/Hir ☐ Other: _____

Emergency Contact: *Name* | *Relationship* | *Home Phone* | *Work Phone*

AUTHORIZATION AND ASSIGNMENT

I voluntarily consent to outpatient care with Desert Senita Community Health Center and/or Dental Center (DSCHC/DSDC), encompassing routine, minor surgical, diagnostic and/or dental procedures. I understand the insurance company I have listed above will be billed for my services. I assign claim payments from the insurance company to be made payable to DSCHC and/or DSDC. I understand that all services may not be covered and I will be financially responsible for balances not covered by my insurance. I understand that any overpayment on my account will be refunded in a timely manner. The attending provider (Doctor, Certified Physician's Assistant, Advanced Registered Nurse Practitioner or Dentist) may disclose any necessary information to Medicare, Medicaid and any third party payer. This authorization and assignment may be revoked by me at any time by written notice.

Signature | **Date**