SAN JUAN BASIN public health

DATE OF SERVICE: _____ **CLIENT REGISTRATION FORM**

Last Name _____First Name _____Middle_____ Maiden/Former: _____

Date of Birth: ___ __ ___/__ __ ___/___ __ ___ (mm/dd/yyyy) Age: _____ Gender: **M** **F**

Patient Telephone: Home (____) _____ Cell (____) _____ Work (____) _____

Patient Mailing Address or PO BOX: _____

City_____ State _____ County_____ Country_____ Zip Code_____

May we mail you test results/reminders (confindential)? Mail: Yes_____ No _____ Phone: Yes_____ No _____

Do you have a Social Security Number? Yes_____ No _____ SSN (last 4) _____ Allergies: _____

Monthly gross income for your family living in the same household (include persons related by blood, marriage, or legal adoption)

$_____

Number (including yourself) supported by this income.

_____

Do you have insurance that covers primary medical care (your visits to the doctor)? Yes_____ No _____
If yes, does it cover Family Planning? Yes_____ No _____
IF YES, WHAT KIND OF INSURANCE DO YOU HAVE _____
A copy of your insurance card is required - Please give it to the front desk

If you are under 17 years of age, do your parents know you are receiving family planning services?
Yes_____ NO_____

If you are 17 years old or younger and covered under your parents' or guardians' insurance plan:
You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder (your parents or guardians) about the health care services you receive at the clinic. Let the clinic staff know if you do not want your parents or guardian to know that you receive services at the clinic.

If you are 18 years old or older and have private insurance coverage and are not the policy holder: You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder about the health care services you receive at the clinic. You may contact your insurance company to request that EOBs be sent to you instead of the policy holder to protect your privacy.

Emergency Contact

Last Name_____ First Name_____ Phone (____)_____ Relationship Type_____

Parent or Guradian if under 18 _____ Phone (____)_____
Please tell us who to contact in case of emergency (parent or guardian if under 18): An emergency would be severe bleeding, unconsciousness, accident or a condition requiring ambulance transport or hospitalization. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.
Does the above person know that you are receiving services here? Yes_____ No _____

I hereby certify that all of the information given, including income, is correct.

_____ _____
Your Signature **Today's Date**

Please see reverse side for Race/Ethnicity and Language questions.

Staff: please circle and initial on back.

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	RACE (CHECK AT LEAST ONE)		ETHNICITY (CHECK AT LEAST ONE)		PRIMARY LANGUAGE (CHECK)
	White		Hispanic Origin		English
	Black or African American		Not Hispanic Origin		Spanish
	American Indian or Alaska Native		Unknown/ Not Reported		Other
	Asian				
	Native Hawaiian or Other Pacific Islander				
	Multiracial-Unspecified				
	Unknown or Not Reported				

For Staff Use Only

Client (IRIS) ID#

Pov. Level _____%

FP Code (Circle one) **01 02 03 04 05 06**

Staff Initials _____ Date ___/___/____

Insurance covering family planning (circle one) **Public Private None Unknown**

Limited english proficiency YES NO

New FP Client? Existing FP Client?

Staff: Please indicate Confidential adolescent patient: YES _____ NO _____