SOUTHWEST COMMUNITY HEALTH CENTER

Patient Registration Form

Today's Date:_____

PATIENT INFORMATION

Patient's Name (First, Middle, Last)			Sex **M / F**	DOB
Email	Address	City	State	Zip
Home Phone	Cell Phone	Primary Language		
Marital Status	Number of Dependents	Annual Income	SSN	Veteran Status **Yes / No**
Employer Name	Address	City	Zip	Phone Number

Race(Please Choose One)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ White ☐ Other Pacific Islander

Ethnicity(Please Choose One)
☐ Hispanic/Latino ☐ Not Hispanic/Latino

GUARANTOR INFORMATION: COMPLETE THIS SECTION IF PATIENT IS A MINOR

Mother's/Guardian's Name	DOB	Email	SSN
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employer Name	Address	City	Zip
Father's/Guardian's Name	DOB	Email	SSN
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employer Name	Address	City	Zip

INSURANCE INFORMATION

(We must obtain copies of ALL insurance and personal identification cards)

Primary Insurance Name	ID/Policy/Number	Group Number	Effective Date
Secondary Insurance Name	ID/Policy/Number	Group Number	Effective Date

Relation to Insured	Is today's visit related to worker's compensation/auto accident? **Yes / No**

Government Issued Identification(Type/Number)
☐Driver's License ☐ID card ☐ Passport ☐Military ID ☐Alien registration card Number: _____

EMERGENCY CONTACT INFORMATION

Name	Relation	Home Phone	Cell Phone
Address	City	State	Zip