Waterfall Community Health Center Patient Registration Adult (15+)

Waterfall Community Health Center 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.

Please choose what specialty of care you would like, select all that apply:

☐ Primary Care ☐ Mental Health ☐ Women's Health ☐ Starfish/Youth Autism ☐ Dental Services ☐ Social Health

PATIENT INFORMATION

First Name: | **Middle:** | **Last Name:** | **Social Security No (SSN):**

Preferred Name: | **Maiden Name:** (if different) | **Birth Date:** / / MO/DAY/YR | **Birth Sex:** __Female __Male

Mailing Address:

Sexual Orientation:
__Straight __Lesbian
__Bisexual __Gay
__Something Else
__Don't Know
__Choose Not to Disclose

City: | **State:** | **Zip:**

Home Phone: | **Cell Phone:**

Identify as (gender identity):
__Female __Male __Other
__Transgender Male: Female-to-Male
__Transgender female: Male-to-Female
__Choose Not to Disclose

Current Marital Status:
__Single __Married
__Divorced __Widow(er)
__Separated

Employment Status:
__ **Employed** __ **Self-Employed** __**Unemployed**
__**Disabled** __ **Retired** __**Student**
Employer (if applicable): _____
Work phone: _____

Living Status:
__Own Home/Rent __ Homeless
__Shelter __Transitional __ Street
__ Unknown __Other: _____

Veteran's Status:
__Veteran __Non-Veteran

FPL (Federal Poverty Level):
Family Size (include Self): _____ **Household Income:** _____
__ Weekly __ Bi-Weekly __ Monthly __ Annually

Race (Choose all that apply):
__ White/Caucasian
__ Black/African American
__ Asian
__ American Indian/Alaskan Native
__ Native Hawaiian
__ Pacific Islander
__ Other
__ Choose Not to Disclose

Ethnicity (choose one):
__ Hispanic/Latino
__ Not Hispanic/Latino
__Choose Not to Disclose

Preferred Language:
__ English __ Spanish
__Other (Specify): _____

Reduced Fees: Are you interested in applying for our reduced fees (even if you are insured)?
___Yes (proof of income will be requested) ___No

Email:
__ I do not have email

Farmworkers:
Does anyone in your household work in the fields or food processing plants? __Yes __ No
If yes, did he/she work in the fields or food processing plants away from this area in the past 24 months? __Yes __No

RESPONSIBLE PARTY

Primary Responsibility Party (Legal and/or Financial **Relationship to Patient:** __ Self __ Spouse __ Parent __Other

First Name: | **Middle:** | **Last Name:** | **Birth Date:** / / | **Social Security No (SSN):**

Address (if different): | **City:** | **State:** | **Zip:** | **Employer:**

INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Primary Medical Insurance	Secondary Medical Insurance
Name of Insurance:	**Name of Insurance:**
Policy Number:	**Policy Number:**
Group Number:	**Group Number:**
Subscriber Name:	**Subscriber Name:**

EMERGENCY CONTACT

Name: | **Relationship to Patient:** | **Phone Number:** | **Alternate Phone Number:**