Please Answer All Questions **(Copy of License or other ID source)**

GROSS MONTHLY HOUSEHOLD INCOME $___________________________________ TOTAL HOUSEHOLD FAMILY MEMBERS _______

HAVE YOU EVER BEEN IN THE U.S. MILITARY? YES ____ NO ___ ARE YOU A MIGRANT FARM WORKER? YES___ NO___

PATIENT INFORMATION:

TODAY'S DATE ______________________ AGE ________________ DATE OF BIRTH _______________________________________

PATIENT LAST NAME_______________________________________FIRST NAME____ MIDDLE INI ______

ADDRESS____ APT # _______________ CITY _______ _____________________ ZIP ___________

HOME PHONE __________________________ CELL ______________ _____________________ SS # ____

SEX: F / M TRANSGENDER (MALE TO FEMALE) (FEMALE TO M ALE) Please Circle: GAY-LESBIAN-BISEXUAL-STRAIT-UNKNOWN

RACE: HISP CAUC AFRO-AMERICAN ASIAN AMERICAN INDIAN HAWIIAN PACIFIC ISLANDER EMPLOYED: YES OR NO
EMPLOYER OR SCHOOL: ____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED WORK/ SCHOOL PHONE___________________________

EMAIL ADDRESS (OF PARENT IF PATIENT IS A MINOR)____

HOW DID YOU HEAR OF OUR CLINIC? FRIEND / FAMILY NEWSPAPER HOSPITAL TELEVISION RADIO OTHER _______________

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(CIRCLE ONE) SPOUSE OR PARENT (IF PATIENT IS MINOR)

LAST NAME____ FIRST NAME____ MIDDLE INI ___________

DOB: __________________ SS# _____________________________________ SEX: MALE / FEMALE LICENSE # ___________________________________

HOME PHONE: ____________________________________ CELL PHONE ________________________________ EMPLOYED: YES / NO

RACE: HISP CAUC BLACK ASIAN PACIFIC ISLANDER AMERICAN IND MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

EMPLOYER____ EMPLOYER PHONE____

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NAME OF LOCAL RELATIVE OR FRIEND (NOT LIVING AT SAME ADDRESS) IN CASE OF EMERGENCY

NAME____ RELATIONSHIP TO PATIENT______________________________

HOME PHONE __________________________________ CELL ______________________ _____ WORK ________________________________

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Insurance Co____ID#____________________________ (NEED COPY OF INS CARD)

Principle INSURED'S Name ____

Insured's SS# ____ Insured's DOB___________________________

Insured's Employer: ____

I affirm that all information given is true and correct as stated. I authorize my insurance benefits to be paid directly to Pasadena Health Center. I understand that I am financially responsible for any balance. I authorize PHC to release any information required to process insurance claims. I give PHC consent for Medical/Dental treatment.

PATIENT/GUARDIAN SIGNATURE____ DATE____________________

Updated 3/27/2020