SOUTHSIDE
Your Community Health Services

**Southside Community Health Services**
Patient Registration Form

## Patient Information

** All Information is kept confidential **

_____ Preferred/Nick name: _____
Last Name First Name Middle Name

Birthdate: _____/_____/_____ Gender at birth: ❑ Male ❑ Female

Gender Identity: ❑ Male ❑ Female ❑ Trans Male ❑ Trans Female ❑ Non-binary/Genderqueer ❑ Other ❑ Choose not to disclose

Sexual Orientation: ❑ Straight ❑ Lesbian/Gay ❑ Bisexual ❑ Pansexual ❑ Queer ❑ Something Else ❑ Choose not to disclose

Pronouns: ❑ She/ Her/ Hers ❑ He/ Him/ His ❑ They/ Them/ Theirs ❑ Other _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Please mark if applicable: ❑ Homeless ❑ Public Housing (not including Section 8)

Best Contact Number: Cell(_____)_____ Home(_____)_____ Work(_____)_____

SSN_____-_____-_____ Email: _____

What is your preferred language? _____ Do you need an interpreter? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Life Partner ❑ Widowed

Emergency Contact: _____(_____)_____ _____
(First and Last Name) (Phone) (Relationship)

Ethnicity: Are you Hispanic/Latino? ❑ Yes ❑ No Birth Country: _____

Race: (Please check all that apply) ❑ White/Caucasian ❑ Black/African American ❑ Asian
❑ Native Hawaiian ❑ Alaskan Native ❑ American Indian ❑ Pacific Islander ❑ Unknown

Are you a veteran? ❑ Yes ❑ No Are you a seasonal worker? ❑ Yes ❑ No Are you a migrant worker? ❑ Yes ❑ No

How did you hear about us? ❑ Relative ❑ Friend ❑ Radio ❑ Newspaper ❑ Southside's Website
❑ TV ❑ Outreach Event ❑ Internet ❑ Other _____

Household Size: _____ Estimated Yearly Household Income: $ _____

## Parent / Guardian Information (if patient is a minor)

Parent/Guardian 1:
Relationship to patient: _____
Name _____
❑Legal Guardian DOB_____/_____/_____
Phone (_____)_____

Parent/Guardian 2:
Relationship to patient: _____
Name _____
❑Legal Guardian DOB_____/_____/_____
Phone (_____)_____