SAN YSIDRO HEALTH

Welcome to San Ysidro Health

Patient Label

Financial Responsibility (Patient or Legal Guardian)

Please complete a registration form if you are a New San Ysidro Health patient or if you need to update your registration information **(You need an "Identification" Card to register, and other documents may be required).**

Legal Name_____Nick Name_____Date of Birth_____

Pronouns: He, Him ☐ She, Her ☐ They, Them ☐ Zie, Hir☐ Unknown ☐ Decline to Answer ☐ Other_____

San Diego County/Southern California Address

Are you homeless or living in a shelter? Yes ☐ No ☐

Address_____City_____State_____Zip Code _____

Other Address:

Address_____City_____State_____Zip Code _____

Social Security #_____Marital Status_____Mother's Maiden Name _____

Home Phone_____**Cell #**_____**E-mail Address** _____

May we send you SMS TEXT Messages to remind you of upcoming appointments? Yes☐ No☐ if you agree, you will be responsible for providing current Cell phone information. You may Opt-Out from receiving TEXT Messages at any time.

Birth Sex: Male ☐ Female ☐ **Current Gender:** Male ☐ Female ☐

Gender Identity: Male ☐ Female ☐ Transgender Male/F – M ☐ Transgender Female/M – F ☐ Non-binary / Genderqueer☐ Other ☐ Choose not to disclose☐

Sexual Orientation:

Straight (Not Lesbian/Gay) ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to disclose ☐

Race: White ☐ Black/African American☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean☐ Vietnamese☐ Other Asian ☐ Samoan ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ American Indian/Alaska Native ☐ Unreported ☐ Chose not to disclose Race ☐

Ethnicity: Hispanic, Latino/a or Spanish Origin ☐ Not Hispanic, Latino/a or Spanish Origin☐ Puerto Rican ☐ Cuban ☐ Mexican, Mexican American, Chicano/a ☐ Another Hispanic, Latina/a or Spanish Origin ☐ Choose not to disclose ☐ Unknown ☐

Contact in Case of Emergency (Other than You):

Name_____Phone#_____Relationship _____

Information:

Do you have a medical problem because of a work injury? Yes ☐ No ☐ Do you have a disability? Yes ☐ No ☐
Do you or any of your dependents have a disability? Yes ☐ No ☐ Are you a Veteran Yes ☐ No ☐
Are you living in Public Housing or receiving Section 8? Yes ☐ No ☐ Are you a Seasonal or Migrant worker? Yes ☐ No ☐
Do you need assistance to pay for medical services? Yes ☐ No ☐ How did you hear of us? _____
What type of medical coverage do you have? Medi-Cal ☐ Medicare ☐ Covered California ☐ Other _____
Do you need your medical records to be transferred to San Ysidro Health? Yes ☐ No☐

Preferred Language: _____ **Need an interpreter? Yes/No**_____

What is your total **monthly** income? **$**_____ Total Family Size (**Including yourself**)? _____

Children or Dependents Information

Name_____Social Security #_____Date of Birth_____ Gender: Male ☐Female ☐

Name_____Social Security #_____Date of Birth_____ Gender: Male ☐Female ☐

Name_____Social Security #_____Date of Birth_____ Gender: Male ☐Female ☐

Contact in Case of Emergency (Parent or Legal Guardian):

Name_____Phone#_____Relationship _____

Patient or Legal Guardian Signature_____Date/ Fecha_____