BORREGOHEALTH

Patient Registration Form

Patient Information

Social Security #: _____ ☐ Refused

First Name, Middle (on insurance ID) _____ Last Name: (on insurance ID) _____

Preferred Name: _____ Preferred Pronoun: ☐ He ☐ She ☐ They ☐ Zie

What is the sex on your birth certificate? ☐ Male ☐ Female ☐ Unknown

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
☐ Genderqueer ☐ Decline ☐ Other (please specify): _____

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual/Pansexual ☐ Queer ☐ Unknown
☐ Refused to Report ☐ Different Identity (please specify): _____

Date of Birth (Month/Day/Year): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian Native
☐ Other Pacific Islander ☐ White ☐ Unreported/Refused to Report

Ethnicity: ☐ Latino/Hispanic ☐ Not Hispanic or Latino ☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ Arabic ☐ Other (please specify): _____ Interpreter needed: ☐ Yes ☐ No

Hearing Impaired? ☐ Yes ☐ No Vision Impaired? ☐ Yes ☐ No

Address: _____ City, State, Zip: _____

Email Address: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred Method of Communication: ☐ Phone ☐ Email ☐ Text

Is Borrego Health your Primary Care Provider? ☐ Yes ☐ No Physician Name: _____

How did you hear about us? _____

Would you like to sign up for the Borrego Health Patient Portal (18+ only)? ☐ Yes ☐ No

If Under 18 | Parent/Legal Guardian/Responsible Party:

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Email Address: _____ Home Phone: _____ Cell Phone: _____

Patient Extended Information | Additional Parent

Sliding Fee Scale Discount Program:
Borrego Health provides comprehensive and high quality primary care services to persons in need, regardless of their ability to pay. At Borrego Health, you will not be turned away even if you do not have health insurance. Sliding fee is a program that may offer you a discount on your medical, dental and behavioral health charges. The program sets a discount on what you pay based on the size of your family and annual income.

Household Size: _____ Household Income: _____ Decline ☐

Would you like to apply for the Sliding Fee Scale Program? ☐ Yes ☐ No

Agricultural (Worker) Status

Have you worked in agriculture in the last 2 years? ☐ Yes ☐ No If yes, was this:

☐ Seasonal (did not move to work) or ☐ Migrant (moved to another area to work in agriculture)

Do you have any dependents? ☐ Yes ☐ No How many? _____

Has anyone in your household worked in agriculture in the last 2 years? ☐ Yes ☐ No If yes, was this:

☐ Seasonal (did not move to work) or ☐ Migrant (moved to another area to work in agriculture)

Are you over the age of 55 or became disabled due to an injury related to agriculture or fieldwork? ☐ Yes ☐ No

Has a family member with whom you reside stopped working in agriculture because of disability or retirement? ☐ Yes ☐ No

Veteran Status

Are you a Veteran of the US Armed Forces? ☐ Yes ☐ No

Primary Insurance: _____ **Member ID:** _____

Emergency Contact Information

Last Name: _____ First Name: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Relationship: _____

Patient Extended Information | Additional Parent

Last Name: _____ First Name: _____

Relationship to Patient: _____ Home Phone: _____ Cell Phone: _____

Patient Extended Information | Pharmacy

Preferred Pharmacy: _____ Pharmacy Address: _____

Patient Extended Information | Patient Information

When was your last dental visit? _____ Dentist Name: _____

I certify that the information I provided to Borrego Health is accurate to the best of my knowledge.
I acknowledge by signing this form that I become a patient of Borrego Health.

Patient/Legal Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY	PLEASE "PRINT" INITIAL	USE BLACK INK ONLY
REG CSR:	**Scanning CSR:**	**Patient#:**