FAMILY AND MEDICAL COUNSELING SERVICE, INC.
REGISTRATION FORM

☐New ☐Renewal ☐ Address Change

Advanced Directive: ☐ Yes ☐ No

Today's Date: ____/____/____

Government Name: _____ **MI:** _____ **DOB:** ___/___/___ **SSN:** _____-_____-_____

Preferred Name (*if different from above*): _____ **Birth Gender:** ☐ Male ☐ Female

Gender Identity	☐ Male ☐ Female ☐ Transgender Female (Male-to-Female) ☐ Transgender Male (Female-to-Male) ☐ Other:_____ ☐ Choose not to disclose
Sexual Orientation	☐ Straight (Not Lesbian or Gay) ☐ Lesbian or Gay ☐ Bisexual ☐ Something Else: _____ ☐ Choose not to disclose

Home #: _____ **Cell #:** _____ **Email Address:** _____

Language: English? ☐ Yes ☐ No **(if no, Other Language):** _____ **Need a translator?** ☐ Yes ☐ No

Special Communication Need? ☐ Hearing Aids ☐ Visual Aids ☐ Sign Language ☐ Cognitive or Attentive Concerns ☐ N/A

Street Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Housing Status Is:
☐ Permanent
☐ Temporary
☐ Public
☐ Homeless

If Homeless:
☐ Shelter
☐ Transitional
☐ Street
☐ Doubling Up ☐ Other

Race:
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White
☐ Decline to Specify

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify

Hispanic Subgroup:
☐ Mexican
☐ Mexican American
☐ Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other
☐ N/A

Asian Subgroup:
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other
☐ N/A

Pacific Islander Subgroup:
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other
☐ N/A

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____ | **United States Citizen?** ☐ Yes ☐ No | **Veteran?** ☐ Yes ☐ No

Are You a Seasonal Agricultural Worker (working in agriculture on a seasonal basis)**?** ☐ Yes ☐ No

Are You a Migratory Worker (seasonal worker who relocates based on job site)**?** ☐ Yes ☐ No

Do you currently receive income? ☐ Yes ☐ No **- If yes, do you have proof of income (recent paystub, SSI statement, etc.)?** ☐ Yes ☐ No

Employee Status: ☐ FT ☐ PT ☐ Unemployed ☐ Other: _____ **Employee Name:** _____

Do you have insurance? ☐ Yes ☐ No **Primary Insured:** ☐ Self ☐ Spouse ☐ Parent

Primary Insurance: _____
Group #: _____ **Policy #:** _____
Phone #: _____

Primary Emergency Contact: _____
Phone #: _____ **Relation to Patient:** _____
Can Agency/Staff's Role be identified to contact? ☐ Yes ☐ No

Secondary Insurance: _____
Group #: _____ **Policy #:** _____
Phone #: _____

Secondary Emergency Contact: _____
Phone #: _____ **Relation to Patient:** _____
Can Agency/Staff's Role be identified to contact? ☐ Yes ☐ No

Allergies: Are you allergic to any food or medicine? ☐Yes ☐ No **If yes, specify**: _____

I AUTHORIZE FAMILY AND MEDICAL COUNSELING SERVICE, INC. TO RELEASE ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS FOR ANY SERVICES MY CHILD RECEIVES. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS, FOR ANY SERVICES I RECEIVE, TO FAMILY AND MEDICAL COUNSELING SERVICE, INC.

Patient Signature: _____ **Date:** ___/___/___ **Staff Signature:** _____ **Date:** ___/___/___

Thank you for completing our registration form. As we strive to improve the quality of our service to you, we may ask you to update this information at other times during the year.

Please present ID, insurance card(s), and proof of income. | **Staff verified:** _____ ☐ ID ☐ Insurance Card(s) ☐ Income