FREDERIKSTED HEALTH CARE, INC.

REGISTRATION

LAST NAME:_____ FIRST NAME_____ MI:_____

Date of Birth:_____ Sex: ☐ Female ☐ Male Social Security #:_____

Mailing Address:_____City:_____ZIP:_____

Telephone #: (Cell):_____(Home):_____(Work):_____

Email Address:_____ Household Size:_____ Annual Income:_____
(See Attachment)

Gender I.D: ☐ Female ☐ Male ☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐ Other: _____ ☐ Prefer not to disclose

Sexual Orientation: ☐ Straight ☐ Bisexual ☐ Lesbian, Gay ☐ Something Else ☐ Don't know ☐ Prefer not to disclose

HOME ADDRESS:_____ CITY:_____

LIVE WITH: ☐ Both Parents ☐ Mother ☐ Spouse ☐ Transitional ☐ Doubling-up ☐ Street ☐ Other

Live near Public Housing: ☐ Yes ☐ No

MARITAL: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

STUDENT: ☐ Full Time Student ☐ Part-time Student ☐ Not a student GRADE:_____

VETERAN: ☐ Yes ☐ No **SMOKER:** ☐ Yes ☐ No **WIC:** ☐ Yes ☐ No

EMPLOYMENT: ☐ Employed Full Time ☐ Employed Part-time ☐ Self Employed ☐ Not Employed ☐ Retired ☐ On Active Military Duty ☐ Unknown

EMPLOYER'S NAME:_____

ETHNIC: ☐ **NON-HISPANIC** ☐ **HISPANIC/ LATINO**

(Select all races that applies to you)

RACE: ☐ Black ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander

In case of an emergency please provide a contact name and telephone:

CONTACT NAME:_____Tel. #:_____ Relationship:_____

If the patient is a child, please provide the PARENT'S INFORMATION:

MOTHER'S NAME:_____SSN #:_____DOB:_____

MOTHER'S MAIDEN NAME:_____

FATHER'S NAME:_____ SSN #:_____DOB:_____

RESPONSIBLE PARTY:_____

MAILING ADDRESS:_____

Do you have Insurance? ☐ **Yes** ☐ **No**

INSURANCE:_____ Effective Date:_____ Expiration Date:_____

I.D. Number:_____ Group Number:_____

Responsible Insured:_____ SSN #:_____DOB:_____

2nd Ins:_____ Effective Date:_____ Expiration Date:_____

I.D. Number:_____ Group Number:_____

Responsible Insured:_____ SSN #:_____DOB:_____

I certify that the information listed above is true and correct to the best of my knowledge.

_____ _____

Patient or authorized person signature Date

Would you be interested in being on the FHC Board of Directors? YES ☐ NO ☐