AVENUE360
HEALTH + WELLNESS

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Last Name: First Name: MI:	Date of Birth: / /	Preferred Name:	Mother's Maiden Name:
Home Address: Apt #	City:	State: Zip Code	County
Preferred Phone: □ Home □ Cell ( ) -	Alternate Phone: □ Home □ Cell □ Work ( ) -		Social Security #:
Marital Status (Check one): □ Single □ Married □ Life partner □ Divorced □ Separated □ Widowed □ Legally Seperated □ Unknown	Name of Spouse:		Email Address:
	What is your current work situation: □ Unemployed □ Part-time □ Full-time □ Choose not to disclose or decline to answer		Are you currently enrolled in school? □ Part-time □ Full-time □ Not Enrolled □ Choose not to disclose or decline to answer
Primary Language: □ English □ Spanish □ Other_____			Do you need a translator? □ Yes □ No

DEMOGRAPHIC INFORMATION

Race: □ African American □ American Indian/Alaska Native □ Asian □ Native Hawaiian □ Pacific Islander □ White □ Unknown/Refuse to report

Are you of Hispanic origin? □ Yes □ No	If Hispanic, please check ethnicity origin: □ Mexican, Mexican American, Chicano(a) □ Puerto Rican □ Another Hispanic, Latino(a) or Spanish Origin □ Cuban □ Unknown/Refuse to report
Are you Homeless? □ Yes □ No	If homeless, please specify: □ Transitional Living Facility □ Street □ Homeless Shelter □ Doubling Up
Do you reside in a Public Housing facility? □ Yes □ No	Do you have an Advanced Directive? □ Yes □ No
Are you a Veteran of the U.S. Armed Forces? □ Yes □ No	

SEXUAL ORIENTATION AND GENDER IDENTITY

What sex were you assigned on your original birth certificate? (Check one): □ Male □ Female □ Choose not to disclose	What are your preferred pronouns? □ He/Him □ She/Her □ They/Them □ Other: _____
Do you think of yourself as? (Check one): □ Straight or heterosexual □ Gay, lesbian, or homosexual □ Bisexual or pansexual □ Asexual or something else □ Questioning or don't know □ Choose not to disclose or decline to answer	To better serve you, what is your current gender identity? (Check one): □ Male □ Female □ Transgender Male/Trans Man/ Female-to-Male (FTM) □ Transgender Female/Trans Woman/ Male-to-Female (MTF) □ Additional Gender Category/ (or Other), please specify: _____ □ Choose not to disclose or decline to answer

EMERGENCY CONTACT INFORMATION

Name of Contact:	Phone Number of Contact:	Relationship to Patient:

HOW DID YOU HEAR ABOUT US?

□ Flyer □ Relative/Friend □ Church □ School □ Event/Fair □ Walk-In □ Hospital □ Internet □ 2-1-1 □ Radio □ Newspaper □ TV □ Magazine □ Eligibility Worker □ Other_____	Social Media: □ Facebook □ Twitter □ Instagram □ Email □ Other: _____

PREFERRED PHARMACY INFORMATION?

Name of Preferred Pharmacy:	Preferred Pharmacy Intersections:	Preferred Pharmacy Phone Number:

I certify that the above information is correct to the best of my knowledge:

_____ _____

Patient / Parent/ Guardian Signature Date

FOR OFFICE USE ONLY

Registration Staff Signature:_____ Date: _____