SOS MEDICAL & DENTAL CLINIC **Patient Registration Form** – Adult

Patient Name: ______________________________
Last First Middle

Address: ______________________________
Street Apt. # City Zip

Phone #: ( ) ( ) ( )
Home Work Cellular

Do you have a **Social Security Number**? ☐ Yes ☐ No Social Security Number: ____________

Date of Birth: ____________ Age: ________ Sex at Birth: ☐ Male ☐ Female
Month / Day / Year

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/ Female-to-Male ☐ Transgender Female/Male-to Female ☐ Other ☐ Choose not to disclose

Sexual Orientation: ☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Something else/other ☐ Don't know ☐ Choose not to disclose

Living Situation: ☐ Own ☐ Rent ☐ Motel/Hotel ☐ Car/Vehicle ☐ Halfway House/Shelter ☐ Homeless Shelter ☐ Transitional ☐ Street ☐ Staying with friends/family - not paying rent ☐ Permanent Supportive Housing ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Are you disabled? ☐ Yes ☐ No **Do you Smoke?** ☐ Yes ☐ No **A female head of household?** ☐ Yes ☐ No

Education level completed: ☐ Less than high school graduate ☐ High school graduate ☐ Some College/Associate's Degree ☐ Bachelor's degree or higher

Are you a:
Migrant Farm Worker?: ☐ Yes ☐ No
Seasonal Farm Worker?: ☐ Yes ☐ No

Race:
☐ American Indian / Alaska Native ☐ White (this includes Latino/Hispanic) ☐ Black/African American
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race ☐ Refuse to Report

Patient Ethnicity:
☐ Non-Latino / Hispanic
☐ Latino/Hispanic
☐ Refuse to Report

What language should your information be provided in? ______________________

Emergency Contact: ______________________ ( )
Name Relationship Telephone #

How did you hear of the S.O.S. Clinic? ______________________

1. Do you have medical insurance? ☐ Yes ☐ No If YES, with what company are you insured? ____________
2. Do you have dental insurance? ☐ Yes ☐ No If YES, with what company are you insured? ____________
3. Do you have Medi-Cal? ☐ Yes ☐ No Have you applied? ☐ Yes ☐ No Policy Number? ____________
4. Do you have MSN? ☐ Yes ☐ No Have you applied? ☐ Yes ☐ No Policy Number? ____________

I understand that my medical/dental information is confidential. I authorize the exchange of information between SOS and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available on request.

I authorize treatment at Share Our Selves. ☐ Yes ☐ No Initials____________

Email address: ______________________
☐ I don't have an email or I would like to OPT OUT of interactive electronic communication with my Care Team at this time.

Adequate numbers of x-rays are required for proper diagnosis. I consent to performing x-rays as needed for my dental treatment:
☐ Yes ☐ No Initials____________

Patient or Legal Guardian Signature: **Date:**