PATIENT REGISTRATION FORM
(Please Print)

South of Market Health Center
Site [ ] 7th St [ ] LoPrest [ ] Clementina
[ ] Bayview [ ] Other _____
[ ] Medical/Dental [ ] Dental Only

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐
Social Security No:	Language(s) Preference:	Birth date:	Age:	E-Mail Address:
Street address/P.O. Box:	City:	State:	ZIP Code:	
Home Phone: ( )	Cell Phone: ( )			

Gender: ☐ Male ☐ Female ☐ Transgender (M/F) ☐ Transgender (F/M) ☐ Other/Unknown ☐ Choose not to disclose

Sexual Orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to disclose

Race:
☐ White
☐ Black/African American
☐ Asian
☐ Native Hawaiian
☐ American Indian or Alaska Native
☐ Other Pacific Islander
☐ More than One Race
☐ Choose not to disclose

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Are you a veteran?
☐ Yes
☐ No

Do you live in Public Housing?
☐ Yes
☐ No

Are you Homeless?
☐ No
☐ Yes, *please √ applicable box →*
☐ Shelter
☐ Street
☐ Doubling-Up
☐ Transitional
☐ Other
☐ Unknown

Do you have a Living Will/ Advance Directive?
☐ Yes
☐ No

Do you have a copy?
☐ Yes
☐ No

Are you Pregnant or here for a pregnancy test?
☐ Yes ☐ No

Family Size _____ Monthly Income $ _____ Discount% _____

You must provide proof of income within 30 days

Source of Income:
☐ Unemployed ☐ SSI/Disability ☐ Denied Disability Income ☐ General Assistance (GA) ☐ SNAP (Food Stamps)

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION *(Please give insurance card(s) to the clerk)*

Person responsible for bill:	Address (If different):	Birth Date:	Home phone#: ( )
Is this person a patient here? ☐ Yes ☐ No	Is the patient covered by insurance? ☐ Yes ☐ No		

Occupation:	Employer Phone #:	Employer Name:	Employer address:

Please indicate primary insurance ☐ Medi-Cal ☐ Medicare ☐ Third Party ☐ Self-Pay ☐ Other

Subscriber's name:	Subscriber's SS#:	Birth date:	Group #:	Policy #:	Co-payment: $

How is this person related to patient? ☐ Self ☐ Spouse ☐ Parent ☐ Other Please List:

Name of secondary insurance (if applicable):

Subscriber's name:	Subscriber's SS#:	Birth date:	Group #:	Policy #:	Co-payment: $

How is this person related to patient? ☐ Self ☐ Spouse ☐ Parent ☐ Other Please List:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The Preceding Information is True to the Best of my Knowledge:

I request SFMCOIP/South of Market Health Center (SMHC) to provide me and/or my child with medical care. I acknowledge my responsibility to pay for that care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental services to be paid to SMHC. I understand I may be eligible to receive a discount on services provided by SMHC. Only services that are medically necessary and ordered by SMHC staff are covered under this program. For those services not covered by this agreement, SFMCOIP Billing Staff will provide assistance to me to make payment arrangements.

X _____
Signature of Patient or Parent/Guardian
Relationship to Patient: _____

_____
Date