HENDERSON WELLNESS CLINIC

Client Registration Form

Today's Date

_____ /_____/ _____

How did you hear about Henderson Wellness Clinic?

- ☐ CDC/SNHD
- ☐ Internet search
- ☐ Online advertisement
- ☐ Billboards
- ☐ Other _____
- ☐ Family/Friend
- ☐ Social media (Facebook, Instagram, Twitter)
- ☐ Newspaper or magazine advertisement
- ☐ Medical provider/hospital

☐ Check the box on the left to keep up to date with Henderson Wellness Clinic's programs, events, workshops, support groups, and other news via email.

☐ Check the box to the left to consent to the receipt of this information via text message.

By checking these boxes, you indicate that you understand Henderson Wellness Clinic cannot guarantee the privacy or security of your device(s) or your network(s).

CLIENT INFORMATION (PLEASE PRESENT YOUR PHOTO IDENTIFICATION AND INSURANCE CARD WITH THIS PAPERWORK)

☐Mr. ☐Ms. ☐Mrs. ☐Dr. ☐None **Legal Name:** First | Middle | Last | Suffix (Jr, Sr, II, III etc.)

Preferred Name/Nickname

Birth Date Mon Day Year _____ /_____/ _____

Are you the patient responsible for all Bills and Insurance? _____

If not, please list name of Responsible person _____

Marital Status: ☐single ☐partnered ☐married ☐divorced ☐separated ☐widowed ☐ other

Street Address | **Apt/STE/Unit** | **City** | **State** | **Zip**

Mobile/Cell Phone ( )

Home Phone ( )

Email Address @

I prefer electronic Statements ☐

Best way to contact me/leave messages (check all that apply): ☐ Phone/ Voicemail ☐ E-mail ☐ U.S. mail

Gender Listed on Insurance/Driver's License ☐Male ☐Female

Social Security Number _____ -_____- _____

Occupation

Employer

Work Phone ( )

Emergency Contact

Phone ( )

Relationship to Client

INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Legal Name of Person Responsible for Bill ☐ Same as Above

Relationship to client if client is not responsible party

Birth Date (if client is not responsible party) _____ /_____/_____

Social Sec Number _____-_____- _____

Street Address (if different) | **City** | **State** | **Zip**

Email Address

Home Phone ( )

Cell Phone ( )

Work Phone ( )

Primary Insurance Company | **Subscriber's Name** | **ID#** | **Group#**

Secondary Insurance Company | **Subscriber's Name** | **ID#** | **Group#**

HENDERSON WELLNESS CLINIC

Demographics Form

Today's Date
_____/ _____/ 20_____

Name on ID/Insurance: First	Middle	Last	New Patient? Yes No
Chosen First Name:		Birth Date: Month / Day / Year	
Have you attended Outreach Events Yes No		Do you receive public benefits (SNAP, medical card, etc.) Yes No	

Pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Only my name ☐ No preference ☐ A pronoun not listed _____

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these questions were provided by our funders; we understand that current demographic categories do not adequately capture our individual identities. Please help us serve you better by selecting the best answers to these questions. Thank you.

Preferred Spoken/Written Language:

☐ English ☐ Spanish
☐ American Sign Language
☐ _____

Language interpretation services needed?

☐ No
☐ Yes, language _____

Sexual Orientation:

☐ Lesbian ☐ Straight
☐ Gay ☐ Something else
☐ Bisexual ☐ Questioning
☐ Queer ☐ Decline to answer

Gender Identity:

☐ Male/Man
☐ Female/Woman
☐ Trans Male/Trans Man
☐ Trans Female/Trans Woman
☐ Genderqueer/Gender nonconforming
☐ Something else
☐ Decline to answer

Sex Assigned at Birth:

☐ Male ☐ Intersex
☐ Female ☐ Decline to answer

Race:

☐ American Indian/Alaska Native
☐ Black and/or African American
☐ White/Caucasian

Asian

☐ Asian Indian ☐ Korean
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Other
☐ Japanese

Native Hawaiian/Pacific Islander

☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

☐ Decline to answer

Ethnicity:

Hispanic/Latino

☐ Mexican
☐ Puerto Rican
☐ Cuban
☐ Other Hispanic/Latino

☐ Not Hispanic/Latino
☐ Decline to answer

Housing Status:

☐ Permanent Housing
☐ Non-permanent Housing
☐ Institution
☐ Homeless
  ☐ Street
  ☐ Homeless Shelter
  ☐ Transitional
  ☐ Doubling Up (not paying rent)
  ☐ Other
  ☐ Decline to answer
☐ Decline to answer

Completed Level of Education:

☐ 1-8 Years
☐ High School Degree
☐ GED
☐ Associate's College Degree
☐ Trade School
☐ Bachelor's College Degree
☐ Master's Degree
☐ Doctorate Degree

Veteran: ☐ Yes ☐ No

Agricultural Worker: ☐ Yes ☐ No

Income

Anticipated annual household income for this year:	Total # people living in household, including you:

I verify the above information is correct to the best of my knowledge.

X_____ ___/___/____
Patient Signature Date

Henderson Wellness Clinic conducts research to help the communities we serve. If you are **NOT** interested in participating, please check the box
☐ **Do not** contact me about research