SmartCare COMMUNITY CLINIC INC

REGISTRATION FORM

SmartCare Community Health Care (SCAMC) attempts to provide low-or no-cost services to the community. NCH MUST obtain the following information about all persons who use NAMC services, no matter what the service is. Please take the moment to answer the following questions as accurately as possible. This information will be kept confidential. You only need to complete this form once (per year) for each type of service/program.

Patient information

First Name:_____ Middle Initial: _____ Last Name:_____

Date of birth:_____ Social Security Number:_____

Home Address:_____ Zip Code:
City State

Cell phone: _____ Email address:_____

Gender (you must select one): __Female __Male __Transgender __Choose not to disclose
Sexual Orientation (you must select one): __Heterosexual(straight) __Lesbian __Gay __Bisexual
Race (you must select one):

☐ Asian	☐ Chinese	☐ Filipino	☐ Native Hawaiian
☐ Korean	☐ Vietnamese	☐ Samoan	☐ African American
☐ Pacific Islander	☐ Guamanian	☐ White	☐ Choose not to disclose
☐ Native Hawaiian	☐ Japanese	☐ American Indian	

Hispanic/Latino Ethnicity(you must select one)
Do you consider yourself Hispanic, Latino, Chicano? ☐ yes ☐ No

Language spoken at home?_____

How many family members are in your household?_____

Total household income: includes social security/disability/unemployment benefits, child support, alimony received (It cannot be $0)

$_____(Select one) ☐ weekly ☐ biweekly ☐ monthly ☐ annually

Are you a veteran? ☐ Yes ☐ No Are you a migrant or seasonal farm worker? ☐ Yes ☐ No
Do you have a lease or mortgage in you or your partner's name? ☐ Yes ☐ No
Insurance: ☐ Medicare ☐ Medical ☐ Self-Pay ☐ None ☐ Public Program:_____
Emergency Contact:

Name:_____ Relationship_____

Phone Number:_____

Address: _____

IF THE PATIENT IS A MINOR:
Please indicate the names of the parents who are responsible for this child
.
Name:_____ Relationship to Patient _____

Name:_____ Relationship to patient_____

Patient Signature:_____ Date:_____