PATIENT REGISTRATION

PLEASE PRINT CLEARLY **TODAY'S DATE _____**

LAST NAME	**FIRST NAME**	**DATE OF BIRTH** / /	**SSN** -- --
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
GENDER FEMALE / MALE TRANSGENDER	**RACE** BLACK / ASIAN AM. INDIAN / WHITE ALASKIAN / PACIFIC IS	**ETHNICITY** HISPANIC / LATINO NON-HISPANIC / LATINO	**STUDENT** MIDDLE SCHOOL HIGH SCHOOL
E-MAIL _____ @ .com	**MOBILE PHONE** ( ) --	**HOME/ALT PHONE** ( ) --	**MARITAL STATUS** SINGLE / MARRIED DIVORCED / WIDOWED
CONSENT TO CALL YES / NO PREFERENCE	**CONSENT TO E-MAIL** YES / NO PREFERENCE	**CONSENT TO TEXT** YES / NO PREFERENCE	**PORTAL REGISTRATION** YES / NO PREFERENCE

MEDICATION HISTORY AUTHORITY
Do we have your permission to download your medication history from your pharmacy? YES / NO
HOW DID YOU HEAR ABOUT THE CLINIC?
Website Social Media Contacted by the Health Dept. Physician / Hospital Referral

ARE YOU EXPERIENCING ANY OF THE FOLLOWING PROBLEMS?

FEMALES
Pain in your stomach? YES / NO
Abnormal or foul smelling discharge from your vagina? YES / NO
Rash, sores, or bumps? YES / NO
Are you on your period? YES / NO
Are you pregnant? YES / NO / Don't know
MALES
Burning with urination? YES / NO
Discharge (drip/ooze) from your penis? YES / NO
Rash, sores, or bumps? YES / NO
Pain in your testicles? YES / NO
If you were contacted by the Department of Health please list the name(s) of recent partner(s) below: _____
OTHER CONCERNS?