CONTRACT PROVIDER
New Patient Registration

1. ADMISSION DATE:

◯ Initial
◯ Update

3. REFERRAL SOURCE:

2. SUBUNIT NAME:

4. LEGAL CLASS

5. LAST NAME:

6. FIRST NAME:

7. MIDDLE NAME:

8. SUFFIX:

9. BIRTH LAST NAME:

10. BIRTH FIRST NAME:

11. BIRTH MIDDLE NAME:

12. SUFFIX:

13. DOB:

14. SSN:

15. ETHNICITY:

16. SEX:

17. ADDRESS:

20. HOME PHONE:

18. CITY STATE ZIP:

21. WORK PHONE:

19. CURRENT SCHOOL:

22. DRIVER'S LICENSE?

23. DL STATE:

24. DL #:

25. BORN IN U.S.?

26. BORN IN CALIFORNIA?

27. CALIFORNIA BIRTH COUNTY

28. STATE OF BIRTH: U.S. ONLY

29. COUNTRY OF BIRTH:

30. MOTHER'S FIRST NAME:

31. MARITAL STATUS:

Select up to 5 Races: ***Separate 2-digit code w/ a comma***

32. RACE:

33. PRIMARY LANGUAGE:

34. LANGUAGE PREFERRED:

01 - White	07 - Chinese	13 - Laotian
02 - Black/African American	08 - Filipino	14 - Samoan
03 - American Indian	09 - Guamanian	15 - Vietnamese
04 - Alaskan Native	10 - Hawaiian	16 - Other Asian
05 - Asian Indian	11 - Japanese	17 - Other Race
06 - Cambodian	12 - Korean	18 - Mixed Race

35. INTERPRETER NEEDED? ◯ Yes ◯ No

EMPLOYMENT/SUPPORT STATUS

36. CURRENT EMPLOYMENT:

37. LIVING ARRANGEMENTS

38. NUMBER OF CHILDREN < 18 YRS , CLIENT CARES FOR 50% OF THE TIME:

39. NUMBER OF ADULTS > 18 YRS , CLIENT CARES FOR 50% OF THE TIME:

40. HIGHEST LEVEL OF EDUCATION

Select up to 8 Disabilities: ***Separate each code w/ a comma***

41. DISABILIY:

1 - None	6 - Mental
2 - Visual	7 - Developmentally
3 - Hearing	8 - Other (not AOD)
4 - Speech	99900 - Client Declined to State
5 - Mobility	99904 - Client Unable to Answer

42. ARE YOU A VETERAN? ◯ Yes ◯ No ◯ Decline

EMERGENCY CONTACT

43. NAME:

44. RELATIONSHIP:

45. ADDRESS:

47. HOME PHONE:

46. CITY STATE ZIP:

48. WORK PHONE:

LEGAL CONTACT

49. LEGAL CONSENT:

50. RESPONSIBLE PERSON:

50. RESPONSIBLE PERSON'S DOB:

DOB Required for Minors Only

50. RESPONSIBLE PERSON'S SSN:

SSN Required for Minors Only

51. ADDRESS:

53. RELATIONSHIP:

52. CITY STATE ZIP:

54. HOME PHONE:

MEDICAL INFORMATION

55. PERSONAL PHYSICIAN:

56. PHONE:

57. CITY STATE ZIP:

58. FAX:

59. PHARMACY:

60. PHONE:

61. FAX:

62. HOSPITAL PREFERENCE:

STAFF NAME:

ID:

PROVIDER:

SIGNATURE:

DATE SIGNED :