Mountain Valleys HEALTH CENTERS

Patient Registration

Patient Demographics

Patient Legal Name _____ Social Security Number _____

Date of Birth: _____ Legal Sex: _____ Gender Identity: _____

Sex Assigned at Birth: _____ Sexual Orientation: _____

Permanent Address: _____

City: _____ State: _____ ZIP Code: _____

County: _____ Country: _____

Phone Numbers:

Mobile _____ ☐ Preferred Contact ☐ May Leave Message ☐ Do Not Call

Home Phone _____ ☐ Preferred Contact ☐ May Leave Message ☐ Do Not Call

Work Phone _____ ☐ Preferred Contact ☐ May Leave Message ☐ Do Not Call

Email Address: _____

☐ No Email

Marital Status: _____ Religion: _____

Single, Married, Widowed, etc. *Christianity, Islam, Hinduism, etc.*

Ethnic Group: _____ Race: _____

Latino-American, African-American, Native-American, Caucasian, etc. *Black, American Indian, Hispanic, White, etc.*

Household Information

Annual Income: $ _____ Family Size: _____

Additional Income Type	$	Other Non Wage	$
Alimony and Child Support	$	Other Wage	$
Government Assistance	$	Pension	$
Hourly Wage	$	Social Security 1	$
Interest & Dividends	$	Social Security 2	$
Monthly Salary	$	Support Secondary Income	$

Employment

Employment Status: _____ Employer: _____

Occupation: _____ Employer Phone: _____

Language

Needs Interpreter? _____ Preferred Language: _____

Written Language: _____ Language Spoken: _____

Fluent in These Languages: _____

Language Needs for Deaf or Hard of Hearing

☐ Contact Lenses ☐ None

☐ Glasses ☐ Other:

☐ Glasses and Hearing Aid ☐ Service Animal

☐ Hearing Aid ☐ Unable to Read or Write

Additional Demographics

Veteran/Military Status: _____ Military Start Date: _____

Military End Date: _____

Nationality Demographics

Country of Origin: _____ Date of Entry: _____

Citizenship Status: _____

Additional Patient Information

Multiple Birth: _____ Multiple Birth Order: _____

Driver's License Number: _____ Driver's License State: _____

Driver's License Expiration Date: _____

Patient Assistance

Low Vision	☐ Yes	☐ No	Hard of Hearing	☐ Yes	☐ No
Memory Impaired	☐ Yes	☐ No	Physically Impaired	☐ Yes	☐ No
Difficulty Dressing or Bathing	☐ Yes	☐ No	Difficulty with Errands	☐ Yes	☐ No

Accommodations

Special Needs:

- ☐ Assistance with Paperwork
- ☐ Contact Lenses
- ☐ Glasses
- ☐ Glasses and Hearing Aid
- ☐ Hearing Aid
- ☐ Large Font Paperwork
- ☐ Longer Appointment Time
- ☐ Low Light
- ☐ Low Sound
- ☐ None
- ☐ Other:
- ☐ Service Animal
- ☐ Unable to Read/Write

Disability Status:

- ☐ Communication Disability
- ☐ Hearing Disability
- ☐ Learning Disability
- ☐ Mental Health Disability
- ☐ Movement Disability
- ☐ No
- ☐ None
- ☐ Not Specified
- ☐ Patient Decline
- ☐ Remembering Disability
- ☐ Social Relationships Disability
- ☐ Speech Disability
- ☐ Thinking Disability
- ☐ Vision Disability
- ☐ Yes

Accessibility Needs:

- ☐ Accessible Exam Table
- ☐ Cane
- ☐ Crutches
- ☐ Elevator
- ☐ None
- ☐ Patient Lift
- ☐ Walker
- ☐ Wheelchair

Please return Patient Registration Form to front office staff with insurance cards and identification.

_____

Patient Signature Date