



**Southside Community Health Services**  
Patient Registration Form

**Patient Information**

*\* All Information is kept confidential \**

Preferred/Nickname: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender at birth:  Male  Female

Gender Identity:  Male  Female  Trans Male  Trans Female  Non-binary/Genderqueer  Other

Sexual Orientation:  Straight  Lesbian/Gay  Bisexual  Pansexual  Queer  Something Else

Pronouns:  She/ Her/ Hers  He/ Him/ His  They/ Them/ Theirs  Other \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please mark if applicable:  Homeless  Public Housing (not including Section 8)

Best Contact Number: Cell(\_\_\_\_) \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_

SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

What is your preferred language? \_\_\_\_\_ Do you need an interpreter?  Yes  No

Marital Status:  Single  Married  Divorced  Separated  Life Partner  Widowed

Emergency Contact: Name \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (Relationship)

Ethnicity: Are you Hispanic/Latino?  Yes  No Birth Country: \_\_\_\_\_

Race: (Please check all that apply)  White/Caucasian  Black/African American  Asian  
 Native Hawaiian  Alaskan Native  American Indian  Pacific Islander  Unknown

Are you a veteran?  Yes  No Are you a seasonal worker?  Yes  No Are you a migrant worker?  Yes  No

How did you hear about us?  Relative  Friend  Radio  Newspaper  Southside's Website  
 TV  Outreach Event  Internet  Other \_\_\_\_\_

Household Size: \_\_\_\_\_ Estimated Annual Household Income: \$ \_\_\_\_\_

**Parent / Guardian Information (if patient is a minor)**

<u>Parent/Guardian 1:</u> Relationship to patient: _____ Name _____ <input type="checkbox"/> Legal Guardian DOB ____ / ____ / ____ Phone (____) _____	<u>Parent/Guardian 2:</u> Relationship to patient: _____ Name _____ <input type="checkbox"/> Legal Guardian DOB ____ / ____ / ____ Phone (____) _____
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