[Patient Label]

Semcac Family Planning Clinic

PATIENT REGISTRATION

Date of Birth: ____/____/_____ **Biological Sex- Female:** ____ **Male:** ____ **Decline to answer:** ____

Identify As- Female: ____ **Male:** ____ **Transgender (FTM):** ____ **(MTF):** ____ **Genderqueer:** ____ **Other:** _____

What pronouns do you prefer? _____

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

Preferred Name: _____ **Phone Number: (_____)** _____

Address:_____**Apt:**_____ **Can we leave a message: Yes** ____ **No:** ____

City: _____ **When calling, how should we identify ourselves?**

State: _____ **Zip:**_____ **Semcac Clinic** ____

Social Security Number: _____-_____-_____ **Other:** _____

Email Address: _____ **Primary Care Provider:** _____

May we send mail to this address?
(all mail is sent with anonymous return)

☐ **Yes** ☐ **No,** If No you are requesting not to receive mail for confidential reasons and must provide us with an alternative address where we may contact you.

Alternative Address: Semcac must be able to contact you by mail.

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Emergency Contact: Name: _____ Relationship:_____

Phone: _____

The following information is used for statistical purposes:

1. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner
2. What race do you identify yourself as? *Mark one or more*
   ☐ White ☐ Native American/Alaskan Native ☐ Asian
   ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other
3. Are you of Hispanic/Latino origin or descent? ☐ Yes ☐ No
4. If you are **less than age 18** are your parent(s)/guardian aware of your visit today?
   ☐ Yes ☐ No

Additional Demographics:

Student Status: ____Yes ____ No

Education Level: ____ 0-8 Grade
____ 9-12 Grade Non-Graduate
____ High School Grad/GED
____ 12+Some Post-Secondary
____ 2/4 Yr College Grad or Beyond

Number of Children Now Living (born to you**):** _____

Military Status: _____ Veteran _____ Active Military _____ None

Disabled: ____ Yes ____No

Housing Type: ____ Own
____ Rent
____ Homeless
____ Other

Household Type: ____ Single Person
____ Single Parent/Female
____ Single Parent/Male
____ 2 Parent Household
____ 2 Adults/No Child

Employment: ____ Yes ____ No
_____ Full-Time
_____ Part-Time
_____ Unemployed (<6 mo)
_____ Unemployed (>6 mo)
_____ Retired

Semcac happily accepts contributions to help us
continue to provide low-cost services to our patients

[Patient Label]

Semcac Family Planning Clinic

INSURANCE INFORMATION
My insurance is: ☐ Public Health Insurance ☐ Private Health Insurance ☐ No Insurance ☐ Unknown

❑ I **want to use** my insurance. Please present all insurance cards to the receptionist.

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

❑ I **do not have** any insurance.

❑ I **do not want** to use my insurance for confidentiality reasons and agree to be responsible for any applicable charges.

FINANCIAL INFORMATION: If you would like to see if you qualify for a discount, please fill out the following. Fees are based on income and family size. You are responsible for the charges for the services you receive.

❑ I prefer to not declare my income, ***and I agree to pay the full price for the services I receive***.

SOURCES OF INCOME: This includes all of yours and your spouse's/partner's pre-taxed wages (including tips); allowance/parental support; public assistance (MFIP, SSI); unemployment compensation; child support; alimony; or veteran's/military allotments.

(Circle One)

Your weekly income is: $_____ **weekly / biweekly / monthly / annually**

Spouse/ Partner's Income: $_____ **weekly / biweekly / monthly / annually**

****Fees for teens seeking confidential services are based on the income of the teen****

*****If you are less than age 18*** **and your parent(s)/guardian are aware of your visit, their weekly income is:**

Weekly income is: $_____

HOUSEHOLD/FAMILY SIZE: How many people, **including yourself**, does this income support? _____

How did you hear about us at Semcac Clinic?
(Please circle all that apply)

Ad/Brochure/Flyer Bar Coaster Facebook Friend Instagram Radio TV Twitter WSU YouTube Other: _____

PATIENT AGREEMENT

☐ **To the best of my knowledge all personal and health related information provided to Semcac Clinic is complete and correct.**

By signing this form and when using insurance, you are stating you AGREE with the following statements:

- **I understand I am responsible for charges for all services, including those not covered by my insurance or grant.**
- **I authorize the release of any medical or other information necessary to process a claim.**
- **I authorize the release of any medical records necessary for continuing care to another health care entity/provider.**
- **I authorize payment of medical benefits to Semcac**
- **I understand that services provided to me may appear on a statement of benefits sent to the policy holder (i.e. parents/spouse)**

Patient Signature: _____ **Date:** _____

THIS SECTION FOR STAFF USE ONLY: Staff Initials: _____ Date: _____

LEP: Y / N Insurance: Public _____ Private _____ Waived _____ Step: _____