CALLEN-LORDE

REGISTRATION FORM

#:________________

PATIENT INFORMATION

Last Name: ☐ First Name: ☐ Middle: ☐ Today's date: ☐

Legal Name (if different): ☐ Date of Birth: ☐ Social Security number: ☐

Billing address: ☐ Apartment #: ☐ Preferred Phone Number: ☐

City: ☐ State: ☐ Zip Code: ☐ Alternate Phone Number: ☐

Pronoun(s): ☐ He ☐ She ☐ They ☐ Ze ☐ A pronoun not listed ☐ No pronoun preference

E-Mail Address for Patient Portal: ☐
*May be used for research studies, if consent given (see page 2).
☐ Do not send marketing communications

Emergency Contact

Emergency contact name: ☐ Emergency contact phone: ☐

The options for some of these questions were provided by our funders; please choose the answer that best fits. Thank You.

Preferred Language:
☐ English ☐ Spanish/Español
☐ American Sign Language (ASL)
☐ Other: ________________

Language interpretation services needed?
☐ Yes ☐ No

Gender Identity:
☐ Male/Man
☐ Female/Woman
☐ Trans Male/Trans Man
☐ Trans Female/Trans Woman
☐ Genderqueer/Gender nonbinary
☐ Another Gender: __________
☐ Decline to Answer

Sex Assigned at Birth:
☐ Male ☐ Female

Race: *Select all that apply*
☐ American Indian/Alaska Native
☐ Black and/or African American
☐ White/Caucasian

Asian:
☐ Asian Indian
☐ Chinese ☐ Korean
☐ Filipino ☐ Vietnamese
☐ Japanese ☐ Other

Native Hawaiian/Pacific Islander:
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

☐ Decline to Answer

Ethnicity:
☐ Non-Hispanic/Latino
☐ Dominican
☐ Cuban
☐ Mexican, Chicano/a
☐ Puerto Rican
☐ Other Hispanic/Latino
☐ Decline to Answer

Sexual Orientation:
☐ Lesbian
☐ Gay
☐ Queer
☐ Bisexual
☐ Straight
☐ Something Else
☐ Decline to Answer

Housing Status:
☐ Stable Housing (not homeless)
☐ Living on Street
☐ Homeless Shelter
☐ Transitional
☐ Pay day-to-day
☐ Doubling Up (not paying rent)
☐ Decline to answer

Veteran?
☐ Yes ☐ No

Migrant Worker?
☐ Yes ☐ No

INSURANCE INFORMATION *Please give card(s) to Front Desk*

☐ I do not have insurance

Insurance carrier: ☐ Policy #: ☐ Group #: ☐

Sex listed on insurance plan: ☐ Male ☐ Female Name on Insurance Card: ☐

Income

Total annual income is $ ☐ Number of dependents (Including self) ☐

Please check which financial documents you are providing:
☐ Pay Stub ☐ Tax Form ☐ Bank Statement
☐ Letter of Unemployment ☐ Letter of Employment/Check Stub ☐ Other (please explain): ☐

If you are unable to provide documentation, check all that apply:
☐ I do not have documentation today ☐ I do not get paychecks or pay stubs ☐ I get paid in cash
☐ I do not earn income ☐ Other reason: ☐

If your annual income does not match your documents. Please explain why:
☐ I am employed for only part of the year (please explain) ☐
☐ My income changes from month to month (please explain) ☐
☐ Other reason (please explain): ☐

I decline to provide any income information. I understand that this decision may affect my ability to receive sliding scale discounts for services I receive.
Initial Here: ☐

I certify that I have provided all of my income information and that all of the above information is true and correct. I understand that this information is required to fulfill grant reporting purposes and will be used to determine eligibility for the Income Based Sliding Fee Scale at Callen-Lorde if I am uninsured. I also understand that if I have intentionally misrepresented my income, I will be asked to repay any discounts I have been given, and may lose my eligibility for discounts in the future. I understand that false information may also lead to discharge from Callen-Lorde.

X ____________________ ____________
Patient Signature Date