Community Medical Wellness Centers USA
YOUR KEY TO WELLNESS

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ _____ _____
First Name Middle Name Last Name

Date of Birth: _____ **Birth Sex:** ☐Male ☐Female **Social Security#:** _____

Home Address: _____ **City** _____ **State** _____ **Zip Code**: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Would you like to receive Voice Messages?
☐ Yes ☐No, do not leave voice messages

Would you like to receive SMS Text Messages?
☐ Yes, I consent to receive SMS from CMWC USA. Reply STOP to opt-out; Reply HELP; message and data rates apply; Messaging frequency may vary www.cmwcusa.org/privacypolicy

☐ No, I do not consent.

Email Address: _____

Community Medical Wellness Center is a Federally Qualified Health Center and is **REQUIRED** to obtain demographic information on all persons who receive services at CMWC. When you share your demographic information, it is kept confidential. It will help us provide you with the best care possible and allows us to maintain funding to provide essential health care services.

1. Race (check ALL that Apply)
☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Burmese
☐ Cambodian/Khmer
☐ Hmong
☐ Laotian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Thai
☐ White
☐ Other _____
☐ Decline to Specify

2. Ethnicity (Select one)
Are you Hispanic or Latino?
☐ Yes ☐ No
☐ Central American
☐ Cuban
☐ Mexican
☐ Puerto Rican
☐ Salvadorian
☐ Other _____
☐ Decline to Specify

3. Language Spoken at Home: _____

4. Do you need interpreter services?
☐ Yes ☐ No

5. Are you a Veteran?
☐ Yes ☐ No

6. Are you a Migrant or Seasonal Farmworker
☐ Yes ☐ No

7. Current Gender
☐ Male☐ Female
☐ Transgender (Male to Female)
☐Transgender (Female to Male)

8. Do you think of yourself as: (Check one)
☐ Straight or Heterosexual ☐Bisexual
☐Lesbian or Gay
☐ Other _____ ☐ Choose not to Disclose

9. Current Living Situation:
☐ House/Apartment ☐Shelter ☐Street/Camp
☐ Transitional ☐ Doubling up (living with

FINANCIAL INFORMATION

Do you currently have health insurance? ☐Yes ☐ No

Name of Insurance: _____ **How Many Family Members in the home?** _____

Total Household Income – include social security/disability/unemployment benefits, child support, alimony, etc. received: Cannot be $0 – must report how you are supporting yourself:

$_____ (select one) weekly/every other week/monthly/annually

EMERGENCY CONTACT INFORMATION

Name _____ **Relationship** _____ **Telephone#**: _____

IF PATIENT IS A MINOR: Please list the name of the parent that is responsible for this child.

Name: _____ DOB: _____ Relationship:☐Parent ☐Guardian

I affirm that the statements made herein are true and correct to the best of my knowledge.

X_____ _____

Patient/Responsible Person's Signature Date

FOR OFFICE USE ONLY
Home Clinic:_____ Data Entered by: _____ Date:_____