DIABETES HEALTH CENTER
PATIENT REGISTRATION

This information is used for statistical purposes and allows us to plan and improve our services.

HIPPA ☐

Name_____Date_____

Address:_____

City_____ Zip code_____

Home Phone_____ Cell Phone_____

Sex ☐ M ☐ F Age _____ Date of Birth_____

Marital Status: ☐ Single ☐Married ☐ Widow ☐ Divorced ☐ Separated

Name of your Husband / Wife / Partner/Parents:_____

Emergency contact name: _____ Phone:_____

Family doctor or primary care provider: _____

Referred by_____

Ethnic background (Please check all that apply)

☐ American Indian ☐ Black/African American ☐ Mexican American /Hispanic_____

☐ Asian_____ ☐ White ☐ Filipino ☐ Other (describe) _____

What language do you usually speak?_____

What kind of work do you usually do?_____

Employer_____ Work phone_____
Are you working now? ☐ Yes ☐ No

What is your monthly family income before taxes?_____

How many adults are in your family / household?_____

How many children are in your family / household?_____

Do you have medical insurance or MediCal or Medicare? ☐ No ☐ Yes

Type:_____ Co-Payment? ☐ No ☐ Yes - amount_____

Responsible Party_____Date of Birth_____

I give my permission for the Diabetes Health Center staff to receive and release information regarding my care to my health care providers and payers

Patient's or Parent Signature_____Date_____