DIABETES HEALTH CENTER
A program of Community Health Trust

PATIENT REGISTRATION FORM

This information is used for statistical purposes and allows us to plan and improve our services. Please note all information given on this sheet is confidential.

PATIENT INFORMATION:

Name: _____ Date of Birth:_____

Address:_____

City: _____Zip code: _____ Email:_____

Home Phone: _____Cell Phone:_____Preffered number: □ Cell □ Home

Marital Status: □ Single □Married □ Widow □ Divorced

Primary Language: _____

PARENT/GUARANTOR INFORMATION:

Name:_____ Date of Birth:_____

Address: _____
(If different than above)

preffered phone number: _____

Spoken Language at Home if Patient is under the age of 13 years old:

Preferred Language for Parent or Guardian:_____

HOW DO YOU IDENTIFY:

RACE:
□ White
□ Black/African American
□ Asian
□ Indigenous

ETHNICITY:
□ Hispanic/ Latino
□ Not Hispanic/ Latino

GENDER:
□ Female
□ Male
□ Non Binary

** What kind of work do you do?_____

** Agricultural (please choose): YES_____ NO_____

EMERGENCY CONTACT:

Name:_____

Relationship: _____Phone: _____

Patient's or Parent's Signature: _____**Date:** _____