Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

Pediatric Patient Registration

Chart No:_____

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth	
Address	City		State	Zip

Child's Birth Weight: _____lbs _____oz	SSN	Email Address
Please check primary phone	Cell Phone ☐ ( )	Home Phone ☐ ( )
Sex at Birth: ☐ Male ☐ Female	Were there any health problems immediately after birth? ☐ Yes ☐No Please explain: _____	
Primary Language: _____	Do you need an interpreter: ☐ Yes ☐ No	

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race:

☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Asian ☐ Other Multi-Racial ☐ White/Caucasian
☐ Black/African American

Patient's Gender Identity:

☐ Male ☐ Transgender Male/Female-to-Male ☐ Other
☐ Female ☐ Transgender Female/Male-to-Female ☐ Choose not to disclose

Patient's Sexual Orientation:

☐ Straight/heterosexual ☐ Bisexual ☐ Don't Know
☐ Lesbian, gay or homosexual ☐ Something else/other ☐ Choose not to disclose

Father's Name: _____	Mother's Name: _____
Father's Date of Birth: _____	Mother's Date of Birth: _____

Are you homeless: ☐ Yes ☐ No	Have you ever been concerned of running out of food: ☐ Yes ☐ No	Are any members of your family migrant farm workers: ☐ Yes ☐ No
Do you have any psychological, spiritual or cultural values that will assist us in your treatment: ☐ Yes ☐ No	Do you want information about Advance Healthcare Directives: ☐ Yes ☐ No	

RESPONSIBLE PARTY (GUARANTOR)

Last Name	First Name	MI	Date of Birth	
Address	City		State	Zip

Please check primary phone	Cell Phone ☐ ( )	Work Phone ☐ ( )	Home Phone ☐ ( )
Relationship to Patient: _____		Preferred Language: _____	

Parent/Legal Guardian Signature: _____

EMERGENCY CONTACT

Last Name	First Name	MI	Contact Phone Number: ( )	
Address	City		State	Zip

Relationship to Patient: _____