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

Adult Patient Registration

Chart No:_____

Please answer all questions to the best of your ability. Your answers are confidential. Camino Health Center utilizes the information you provide to continuously evaluate existing programs and services. Additionally, Camino Health Center receives grant funding which requires the heath center to provide statistics on its patient population. If you have any questions about this registration form, please ask a Patient Services Representative at the front desk for assistance.

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth	
Address	City		State	Zip
Other Name(s) Used	SSN	Email Address		
Please check primary phone	Cell Phone ☐ ( )	Work Phone ☐ ( )	Home Phone ☐ ( )	

Primary Language: _____ Do you need an interpreter: ☐ Yes ☐ No

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

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

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Other Multi-Racial
☐ Other Pacific Islander
☐ White/Caucasian (Hispanic/Latino)

Sex at Birth: ☐ Male ☐ Female

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Choose not to disclose

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

Highest Level of School Completed:
☐ 11th Grade or Less
☐ High School Diploma/GED
☐ Associates Degree
☐ Bachelor's Degree
☐ Graduate Professional Degree

Are you employed:
☐ Full-Time
☐ Part-Time
☐ Unemployed

Are you homeless:
☐ Yes
☐ No

Are any members of your family migrant farm workers:
☐ Yes
☐ No

Have you ever been concerned of running out of food:
☐ Yes
☐ No

Do you have any psychological, spiritual or cultural values that will assist us in your treatment:
☐ Yes
☐ No

Do you have an Advance Health Care Directive:
☐ Yes
☐ No

EMERGENCY CONTACT

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

Relationship to Patient: _____

Patient Signature: _____ Date: _____