HURTT familyhealth CLINIC

Account Number: ____________

2021 Annual Registration Form

Dear Patient: In order to provide you with the best care possible, we require each patient's information to be updated on an annual basis. This practice serves all patients regardless of inability to pay. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis.

Patient Information

Last Name	First Name	MI	Date of Birth

Address	Apt./Unit	City	State	Zip Code

SSN	Sex	Email Address
	☐ Male ☐ Female	

Please check primary phone	☐ Cell Phone	☐ Work Phone	☐ Home Phone
	( )	( )	( )

Have you downloaded the Hurtt Family Health Clinic Patient Portal? ☐ Yes ☐ No

Check the box that best describes your general health:

Living Arrangements (Please check one):

- ☐ **Permanent Residence** (own, rent apartment/room/house)
- ☐ **Shelter** (safe havens, temporary overnight housing, armories)
- ☐ **Transitional** (center, community, home)
- ☐ **Street** (sidewalk, car, park, doorway, public or abandoned building)
- ☐ **Doubling Up** (living with other people for a temporary period and move often)
- ☐ **Other** (hotel, motel, day-to-day single room occupancy)

Race (Please check all that apply):

☐ Caucasian ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian
☐ Black or African American ☐ American Indian/Alaskan Native ☐ Other/Choose Not to Disclose

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

Birth Sex: ☐ Male ☐ Female

Gender Identity:

☐ Male ☐ Transgender Male/Female-to-Male ☐ Other: ___________
☐ Female ☐ Transgender Female/Male-to-Female ☐ Choose Not to Disclose

Sexual Orientation:

☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't know ☐ Choose Not to Disclose ☐ Other: ___________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you a Veteran: ☐ Yes ☐ No

Do you have an Advanced Directive: ☐ Yes ☐ No

Health Insurance: ☐ Medicare ☐ Medi-Cal ☐ None ☐ Other: __________

Have you downloaded the Hurtt Family Health Clinic Patient Portal? ☐ Yes ☐ No

Please check the box that best describes your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Spouse or Parent/Guardian Information: (If applicable)

Last Name	First Name	Date of Birth

Please check primary phone	☐ Cell Phone	☐ Work Phone	☐ Home Phone
	( )	( )	( )

Emergency Contact:

Last Name	First Name	Relation to the Patient	Phone Number
			( )

I acknowledge that I have filled out the included information to the best of my abilities and understand that if any of my information changes or needs to be updated, that I will inform Hurtt Family Health Clinic.

Signature:	Relationship to patient, if not patient:	Date: