Mora Valley Community Health Services, Inc.

(Requested information is required by our funding sources.)

Patient Registration

(Please Print)

Date: _____ Home Phone #: _____ Cell Phone #: _____ Work Phone #:_____

Name: _____ Social Security #: _____

Mailing Address: _____
City State Zip Code

Physical Address: _____

Sex: M___ F___ Age: ____ Birth date: _____ Patient Portal Access: Yes ___ No ___ if yes, **Email**: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Household Yearly Income: $ _____ Number of Household Members: _____

Employer: _____ Occupation: _____

Business Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Sexual Orientation:
- **Straight/heterosexual** _____
- **Gay, lesbian, or homosexual** _____
- **Bisexual** _____
- **Something Else** _____
- **Don't Know** _____
- **Choose Not to Disclose** _____

Transgender:
- **Female to Male** _____
- **Male to Female** _____
- **Other _____**
- **Choose Not to Disclose** _____

Yes No

☐ ☐ Veteran Status: Have you completed service in the uniformed services of the United States?
☐ ☐ Are you of Hispanic/Latino ethnicity?
☐ ☐ Are you best served in a language other than English? If yes, which _____?
☐ ☐ Migrant
☐ ☐ Homeless
☐ ☐ Seasonal Worker

Please select your race, select all that apply

☐ American Indian/Alaska Native
☐ Asian ☐
☐ Native Hawaiian
☐ Black/African American
☐ White (including Whites of Latino/Hispanic decent)
☐ Pacific Islander
☐ Other

ACCOUNT RESPONSIBILITY

Person responsible for the account: _____
Last Name First Name

Relation to Patient: _____ Birth date: _____ Social Security #: _____

PRIMARY INSURANCE

Subscriber Name: _____ Relation to patient: _____ Birth date: _____

Insurance Company: _____ Social Security #: _____

Names of other dependents covered under this plan: _____

ADDITIONAL INSURANCE

Subscriber name: _____ Relation to Patient: _____Birth date: _____

Insurance Company: _____

Names of other dependents covered under this plan: _____

Signature (Patient or Parent if Minor): _____ Date: _____