BRIGHTER BEGINNINGS
Every Family Matters

COVID-19 NEW PATIENT REGISTRATION FORM

Patient DOB: ___________ Today's Date: ____________

Please fill out completely and ask for help if you have questions. Thank you!

Last Name: ______________________________ **First Name:** ________________ **Middle Name:** _____________

Address: ____
Street City State Zip

Home Phone: _________________ **Cell Phone:** ____________________ **Email:** ________________________

Preferred Pharmacy: ____
Name City Street

What language are you most comfortable speaking? ❒ English ❒ Spanish ❒ Other: ___________

How well do you understand English? ❒ Very well ❒ Moderate ❒ Very little ❒ Not at all

Do you have a Social Security Number: ❒ Yes ❒ No **or ITIN:** ❒Yes ❒No

Social Security OR ITIN #: ______________________________

Is your Social Security # for employment only? ❒Yes ❒No

Name of emergency contact: ___________________________ **Relationship:** ____________________________
Phone: ( ) _________________________

If minor, Parent 1's name: _______________________ **If minor, Parent 2's name:** _________________________

1. **Do you have health insurance?** ❒Yes ❒No **If YES, what insurance company?** ______________________

2. **Do you have Medi-Cal:** ❒Yes ❒No

   If YES, is it Emergency Medi-Cal? ❒Yes ❒No

3. **Do you have Contra Costa Health Plan?** ❒Yes ❒No

   If NO, have you applied? ❒Yes ❒No

Your answers to the following questions will help us best serve you and continue to provide services to our community. Like all of your health information, these replies will be kept confidential and protected.

Is seasonal or migrant farm work your or your family's main source of income?
❒ Seasonal ❒ Migrant ❒No ❒ Prefer not to say

What is your current housing situation?
- ❏ Rent
- ❏ Own
- ❏ Staying at a family member or friend's
- ❏ Hotel or motel
- ❏ Car
- ❏ Shelter

Have you been discharged from the armed forces of the United States?
❒ Yes ❒ No ❒ Prefer not to say

What is your race? Check all that apply:
- ❏ American Indian / Native Alaskan
- ❏ Asian
- ❏ Black / African-American
- ❏ Native Hawaiian
- ❏ Pacific Islander
- ❏ White

- ❏ Street, encampment, or outdoors

Are you hispanic or Latino?
❏ Yes ❐ No ❐ Prefer not to say

How many people live in your household? ________

What is the total combined annual income for you and your household? ___________________________

Education level completed:
❐ Less than high school graduate
❐ High school graduate
❐ Some College/ associate degree
❐ Bachelor's degree or higher

Employment Status
- ❏ **Employed full time**
  Name of employer: __________________
  Job title: ____________________________
- ❏ Employed part time
- ❏ not employed

Are you disabled? ❐Yes ❐No
Marital Status:

- ❏ Single
- ❏ Married
- ❏ Separated
- ❏ Divorced
- ❏ Widowed
- ❏ Domestic partner

How did you hear about our clinic?

____

- ❏ Other
- ❏ Prefer not to say

Do you think of yourself as:
- ❏ Lesbian, gay or homosexual
- ❏ Straight or heterosexual
- ❏ Bisexual
- ❏ Something else (please specify): ___________
- ❏ Don't know
- ❏ Decline to answer

What is your current gender identity? (please select all that apply)
- ❏ Male
- ❏ Female
- ❏ Trans Man/Transgender Male
- ❏ Trans Woman/Transgender Female
- ❏ Genderqueer or nonbinary
- ❏ Other, please specify:____________
- ❏ Decline to answer

What sex were you assigned at birth on your original birth certificate? (please select one)
- ❏ Female
- ❏ Male

What are your preferred pronouns?
- ❏ She / her
- ❏ He / him
- ❏ They / them
- ❏ Other: _________

I understand that my medical information is confidential. I authorize the exchange between this clinic and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. A copy of Patient Rights and confidentiality policies are available upon request.

I HEREBY AUTHORIZE COVID-19 TESTING, TREATMENT, AND VACCINATION BY THE BRIGHTER BEGINNINGS CLINIC:

❐Yes ❐No **Initials:** _____

Patient Signature or Guardian: ___________________________________ **Date:**____________