RIVERLAND COMMUNITY HEALTH

1026 West 7th St
St. Paul, MN 55102
651-758-9500

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Patient's Name (Last, First, MI):	Preferred Name:	Date of Birth: ___/___/_____ MM / DD / YYYY

What sex were you assigned on your original birth certificate? (Check one): ☐ Male ☐ Female | SSN: ___ ___/___ ___/___ ___ ___ ___

Primary Language: | Do you need an Interpreter? ☐ Yes ☐ No

Home Address: Apt #	City:	State:	Zip Code:

Preferred Phone (Check one): ☐ Home ☐ Cell ( )	Secondary Phone: ☐ Home ☐ Cell ( )	Email:

Marital Status (Check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Life Partner ☐ Widowed

DEMOGRAPHIC INFORMATION

***As a federally funded community health clinic, we are required to collect certain demographics, all information is kept confidential.**

Race (Select all that apply): ☐ Black/African American ☐ American Indian/Alaska Native ☐ White

☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ Choose not to answer

Are you of Hispanic origin?
☐ Yes ☐ No
☐ Choose not to answer

If Hispanic, please check ethnicity origin: ☐ Mexican, Mexican American ☐ Puerto Rican
☐ Another Hispanic, Latino(a) or Spanish Origin ☐ Cuban ☐ Unknown ☐ Choose not to answer

Please mark if applicable: ☐ Experiencing homelessness | What is your country of origin?________________________

Are you a (US) veteran? ☐ Yes ☐ No
Are you an agriculture seasonal worker? ☐ Yes ☐ No
Are you an agriculture migrant worker? ☐ Yes ☐ No

Household Size: __________
Estimated Yearly Household Income: $ __________
You may qualify for a Sliding Fee Discount

Do you identify as? (Check one):
☐ Straight or heterosexual
☐ Gay, lesbian, or homosexual
☐ Bisexual or pansexual
☐ Asexual or something else
☐ Questioning or don't know
☐ Choose not to answer

What are your pronouns?
☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:____________

To better serve you, what is your current gender identity? (Check one):
☐ Male
☐ Female
☐ Transgender Male/Trans Man/ Female-to-Male (FTM)
☐ Transgender Female/Trans Woman/ Male-to-Female (MTF)
☐ Additional Gender Category/Other
please specify: ____________________
☐ Choose not to answer

EMERGENCY CONTACT INFORMATION

Name of Contact:	Phone Number of Contact:	Relationship:

PARENT / LEGAL GUARDIAN INFORMATION (if patient is a minor or not their own guardian)

Parent/Legal Guardian 1:
Relationship to patient: ______________________
Name ______________________
Phone ( )
☐ Legal Guardian DOB _____/_____/_____

Parent/Legal Guardian 2:
Relationship to patient: ______________________
Name ______________________
Phone ( )
☐ Legal Guardian DOB _____/_____/_____

Person Completing the form

______________________ ______________________ __________
Printed Name Signature Date

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Responsible Party	
Name of person responsible for this account:	
Relationship to patient:	
Address:	
Phone:	
Is this person currently a patient in our office:	
Insurance Information	
Name of Insured:	
Birthdate:	
Name of Employer:	
Insurance company:	
Group #:	
Policy ID #:	
Do you have a co-pay:	If yes, how much:
If you have additional insurance, please complete the below section	
Name of insured:	
Name of employer:	
Insurance company:	
Group #:	
Policy ID #:	
Do you have a co-pay:	If yes, how much: