Patient Information

Social Security #: ❑Refused	First Name, Middle *(on insurance ID)*	Last Name: *(on insurance ID)*
Name to Use:		**Preferred Pronoun:** ❑He ❑She ❑They ❑Zie

What is the sex on your birth certificate?: ❑M ❑F ❑N or X

Gender & Sex: ❑Male ❑ Female ❑Trans man ❑ Trans woman ❑ Genderqueer ❑ Non -Binary

Current Gender Identity: ❑ Different identity *(please specify):* ____

Sexual Orientation: ❑ Straight/Heterosexual ❑ Lesbian/Gay/Homosexual ❑ Bisexual/Pansexual ❑ Queer ❑ Unknown ❑ Refused to report ❑ Different identity (please specify): ____________________________

Date of Birth*:* ***Month/Day/Year:*** ________/________/________

Race: ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑ Hawaiian Native ❑ Other Pacific Islander ❑White ❑ Unreported/Refused to Report

Ethnicity ❑Another Hispanic, Latino or Spanish Origin:______________________ ❑Not Hispanic/Latino ❑ Unreported/Refused to Report

Preferred Language: ❑English ❑Spanish ❑Arabic ❑Other, *(please specify)*:________________________________

Street Address/City/State/ZIP:

Email Address:			How did you hear about us?
Home Phone:❑ *Preferred*	Cell ❑ *Preferred*	Work ❑ *Preferred*	**Would you like to use the Borrego Health Text Message Reminders?** ❑YES ❑NO

Is Borrego Health your Primary Care Provider? ❑YES ❑NO | **Physician Name:**

Sliding Fee Scale: You may qualify for assistance to pay for some health services.	Household Size: ______________ Household Income: ____________	Would you like to apply for the **Sliding Fee Scale Program**? ❑YES ❑NO

Housing Status:	❑ Not Homeless (Rent, Own) ❑ Doubling Up ❑ Homeless Shelter ❑ Public Housing ❑Street ❑ Transitional
Agricultural Status	Have you or anyone in your household worked in the fields in the last 2 years? ❑YES ❑NO
Veteran Status	Are you a Veteran of the US Armed Forces? ❑YES ❑NO Dependent of a Veteran? ❑YES ❑NO

Primary Insurance: **Member ID:**

Emergency Contact Information

Last Name:	First Name:		
Relationship:	Home Phone	Cell	Work:

If Under 18 -Parent/LegalGuardian/ResponsibleParty:

Last Name:	First Name:		DOB:
Address: ❑*Same as Patient*		Home Phone	Cell:

Patient Extended Information-Additional Parent

Last Name:		First Name:	
Relationship to Patient:		Home Phone	Cell:
Preferred Pharmacy:		When was your last Dental visit?	
Pharmacy Address:		Dentist Name:	
Hearing Impaired? ❑ Yes ❑ No	Vision Impaired? ❑ Yes ❑ No	**Would you like to use the Borrego Health** Patient Portal? (18+ only) ❑YES ❑NO	

I certify that the information I provided to Borrego Health is true to the best of my knowledge. I acknowledge by signing this form I become a patient of Borrego Health.

Patient/ Legal Guardian Signature:____**Date:** __________

FOR OFFICE USE ONLY	PLEASE "PRINT" INITIAL	USE BLACK INK ONLY
REG CSR:	Scanning CSR:	Patient#: