El PASO COUNTY PUBLIC HEALTH

REPRODUCTIVE HEALTH CLINIC – REGISTRATION FORM

Today's Date:_____
First Name: _____ Middle Initial: ____ Last Name: _____
Date of Birth: _____ Maiden/Former Name: _____
Address: _____ Unit/#: _____
City: _____ State: _____ Zip: _____ County: _____
Is it OK to send mail to this address? Y N
Phone: _____ (home, cell, work) **OK to Leave Message?** Y N Text? Y N
Alternate Phone: _____ (home, cell, work) **OK to Leave Message?** Y N Text? Y N
Email Address: _____**OK to email?** Y N

Ethnicity:	**Race (check at least one):**	**Primary Language:**
□ Hispanic Origin	□ American Indian/Alaskan Native	□ English
□ Non-Hispanic Origin	□ Asian	□ Spanish
	□ Black/African American	□ Other:
What sex were you assigned at birth?	□ Native Hawaiian/Pacific Islander	
□ Female	□ White	
□ Male		
□ Intersex		
What is your gender identity:	**Do you think of yourself as:**	**What is your preferred pronoun:**
□ Female	□ Bisexual	□ He/Him/His
□ Male	□ Gay	□ She/Her/Hers
□ Intersex	□ Lesbian	□ They /Them/Theirs
	□ Pansexual/polysexual	□ Ze/Hir/Hirs (pronounced "zee")
	□ Straight/Heterosexual	□ Hir, hirs (pronounced "here")

Have you had any of the following procedures/conditions?
□ Hysterectomy
□ Tubal Ligation (Tubes tied)
□ Vasectomy
□ Menopause
□ NONE of the above

Emergency Contact Information: Please tell us who to contact in case of emergency (parent or guardian if under 18): An emergency would be severe bleeding, unconsciousness, accident or a condition requiring ambulance transport or hospitalization. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.

Emergency Contact Name & Relationship: _____ Phone Number: _____

Does this person know that you are receiving services here? Yes No

Services are based on a sliding fee scale according to household income. If you have insurance, including Medicaid, we will bill your insurance first. Any patient responsibility after insurance payment will be assessed using the sliding fee scale.

Everyone needs to answer the following questions so that we can correctly assess your situation.

How many people live in your home?_____

How many people living in your home are employed?_____

For each employed person in your home please fill out the following:

Employed Person	Gross Income (before taxes)	Weekly, Monthly or Yearly?
#1		
#2		
#3		

Does anyone in your home receive any of the following?

	Circle One	Monthly Amount
Unemployment	YES NO	
Child Support	YES NO	
Food Stamps/SNAP	YES NO	
TANF	YES NO	
VA Benefits	YES NO	
SSI/SSID	YES NO	
Housing	YES NO	

If no one in your home is employed or receiving benefits, please tell us how you/your household are being supported. Include money received from family, friends, student loans or savings and free rent or food.

Do you have Medicaid? YES NO Medicaid # _____
Do you have private insurance? YES NO
Name of private insurance Company _____
Please have your insurance card ready to give to the front desk person
TriCare Patients:
Name of Sponsor: _____
Sponsor date of birth:_____ Sponsor SSN:_____

If you are 17 years old or younger and covered under your parents' or guardians' insurance plan:

You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder (your parents or guardians) about the health care services you receive at the clinic. Let the clinic staff know if you do not want your parents or guardian to know that you receive services at the clinic.

If you are 18 years old or older and have private insurance coverage and are not the policy holder:

You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder about the health care services you receive at the clinic. You may contact your insurance company to request that EOBs be sent to you instead of the policy holder to protect your privacy.