Sea Mar
Community Health Centers
Clínica de la Comunidad
Exceptional service. Every person. Every time.

Patient Registration Information

Please print and complete all sections below

Is your condition a result of a work injury? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Date of Injury? / /

Patient Demographic Information

Patient's Name: ____
LAST FIRST MIDDLE SOCIAL SECURITY #

Other names used: ____

Date of Birth: _____/_____/_____
MO DAY YR

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Mailing Address: ____
STREET CITY STATE ZIP

Permanent Address:____
STREET CITY STATE ZIP

I give permission to receive mail at this address: ☐ Yes ☐ No
E-Mail address: ______________________________

Primary Phone (____) _______________

Phone Type: ☐ Home ☐ Work ☐ Mobile ☐ Voice Mail ☐ Other

I give permission to: ☐ Call Anytime – Leave Messages ☐ Call Anytime – Never Leave Messages
☐ Call Morning Only– Leave Messages ☐ Call Morning Only – Never Leave Messages ☐ Call Evenings Only – Leave Messages
☐ Call Evenings Only – Never Leave Messages ☐ Never Call

Alternative Phone (____) _______________

Phone Type: ☐ Home ☐ Work ☐ Mobile ☐ Voice Mail ☐ Other

I give permission to: ☐ Call Anytime – Leave Messages ☐ Call Anytime – Never Leave Messages
☐ Call Morning Only– Leave Messages ☐ Call Morning Only – Never Leave Messages ☐ Call Evenings Only – Leave Messages
☐ Call Evenings Only – Never Leave Messages ☐ Never Call

Employment:

☐ Paid full-time 35+ hrs/wk ☐ Paid part-time <25 hrs/wk ☐ Supported Employ, Comm. Based ☐ Volunteer Work 1+ hr/wk
☐ Not employed – retired ☐ Not employed – other ☐ Unemployed

Occupation: ____________________
Annual Income:_____________
Number of Dependents: ______________
Currently Pregnant: ☐ Yes ☐ No

Race (Ethnicity)

☐ 01- Not Spanish/Latino	☐ 09- Black/African American	☐ 17- Asian Indian	☐ 25- Samoan
☐ 02- Mexican	☐ 10- American Indian	☐ 18- Chinese	☐ 26- Other Pacific Island
☐ 03- Cuban	☐ 11- Cambodian	☐ 19- Filipino	☐ 27- Bosnian
☐ 04- Puerto Rican	☐ 12- Laotian	☐ 20- Japanese	☐ 28- Iranian
☐ 05- Central American	☐ 13- Vietnamese	☐ 21- Korean	☐ 29- Iraqi
☐ 06- South American	☐ 14- Russian/Ukranian	☐ 22- Thai	☐ 30- Other Race
☐ 07-Unknown	☐ 15- Aleut	☐ 23- Guamanian/Chamorro	☐ 31-Not Reported/Unknown
☐ 08- Caucasian/White	☐ 16- Eskimo	☐ 24- Native Hawaiian	☐ 32- Multi Racial

Grade Level:

☐ Elementary Grade: ____ ☐ High School Grade: ____ ☐ Complete HS/GED ☐ Some College
☐ 2 yr. degree ☐ 4 yr. degree ☐ Vocational ☐ Post-graduate education

Type (Race)

☐ 01- Asian ☐ 03- Pacific Islander ☐ 5- American Indian ☐ 7-Multiracial
☐ 02- Native Hawaiian ☐ 4-Black ☐ 6-White ☐ 8-Other

Have you or anyone in your household been a: ☐ Migrant or ☐ Seasonal farm worker in the last two years?

Are you homeless: ☐ Yes ☐ No If so, what is your living situation: ______________________________
Residential Arrangement (i.e. paying your own rent, crisis shelter, transitional housing) : ______________________________

Student Status: ☐ Yes ☐ No

Education: ☐ Full Time ☐ Part Time ☐ No education activity

Emergency Information

Emergency Contact: ______________________________ Relationship: ______________________________

Primary Phone: ______________________________ Is it a: ❒ Day number ❒ Night number (only for TX facilities)

Secondary Phone: ______________________________ Is it a: ❒ Day number ❒ Night number (only for TX facilities)

Additional Information

Do you have a disability? ☐ Yes ☐ No If yes, what kind: ______________________________

What language are you best served in: ______________________________ Do you require interpreter services? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No Are you active in the military: ☐ Yes ☐ No

If yes, What Branch? ______________________________

Dates of Service: From __________ to ____________

Is anyone in your family a veteran or active in the military? ☐ Yes ☐ No

Smoking Status: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker

Referral Source

☐ Self/ Family ☐ Substance Use Disorder Provider ☐ Mental Health Provider ☐ Other HealthCare Provider ☐ Self Help Group
☐ School ☐ Employer ☐ Court/Criminal Justice ☐ Other community Referral

Responsible Party Information

Responsible Party: ____
LAST FIRST MIDDLE SOCIAL SECURITY #

Address: ____ Home Phone: ______________
STREET CITY STATE ZIP

Date of Birth: ____/____/____ Relationship to Patient: ☐ Self ☐ Guardian/Parent if minor ☐ other (L&I, MVA)
MO DAY YR

Medical Insurance Information

Insurance Company (Primary): ______________________________

Insurance Co. Address: ______________________________
STREET CITY STATE ZIP

Policy No. /Member ID#: ______________ Group No.: ______________

Subscriber Name: ______________ Subscriber DOB: ______________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Co-pay: __________

Insurance Company (Secondary): ______________________________

Insurance Co. Address: ______________________________
STREET CITY STATE ZIP

Policy No./Member ID# : ______________ Group No.: ______________

Subscriber Name: ______________ Subscriber DOB: ______________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Co-pay: __________

Other Information

Who is your Primary Physician? Who is your Sea Mar Dentist?

Has any other member of your family been seen at this facility? ☐ Yes ☐ No If YES please name:

Are you a Female head of household? ☐ Yes ☐ No

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Community Demographic Form

Please complete the form below. If you have any questions or concerns, please ask your clinician during the appointment.

Patient Name:	Patient ID:
Patient Preferred Name:	
Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other ______	

Gender Identity

What sex were you assigned at birth on your original birth certificate (check one)?
☐ Male ☐ Female ☐ Intersex ☐ Decline to Answer

Do you think of yourself as (check one):
☐ Man
☐ Woman
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Gender Queer, neither exclusively male or female
☐ Additional gender category/Other, please specify: ______
☐ Decline to Answer

Sexual Orientation

Do you think of yourself as (check one):
☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual
☐ Something else, please specify: ______ ☐ Don't know ☐ Decline to Answer

Migrant and Seasonal Farmworker Status

In the past two years, have you or a member of your family worked in agriculture/farming, forestry or fisheries as your/their main employment including, but not limited to: Preparing, irrigating or spraying the fields, nurseries, orchards; Planting, picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; Planting trees, working with Christmas trees, picking pine needles or Spanish moss; Working on farms that produce chicken, ducks, turkeys, cows, goats, sheep, horses, fish, seafood, etc.?
☐ Yes ☐ No

In the past two years, have you or a member of your family established a temporary home in order to work in agriculture?
☐ Yes ☐ No

Have you or a member of your family stopped the need to establish a temporary home to work in agriculture because of disability or old age?
☐ Yes ☐ No

In the past two years, have you or a member of your family worked in agriculture on a seasonal basis without the need to establish a temporary home?
☐ Yes ☐ No

Housing Status

Are you currently living with friends or family, in your car, in a shelter, in a hotel, or on the street? ☐ Yes ☐ No

If yes, please choose one of the following that best describes your current situation:
☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional Housing ☐ Decline to Answer

Other Demographics

Are you a US Veteran? ☐ Yes ☐ No

Patient Acknowledgement: I have read and understood the above information and declare the information furnished to be to be true and complete to the best of my knowledge.

______________________ ______________
Patient Signature Date

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Financial Screening Form

To comply with federal regulations and provide you a discount on Sea Mar services, it is necessary for you to fill out this form, answer some personal questions, and provide proof of income. Your answers will be kept on file and in strict confidence.

Patient Name:	DOB:	Patient ID:
Household Size:	Annual Income:	☐ I choose NOT to provide my income.

☐ **I choose NOT to apply for the sliding fee scale.** Please sign and date below.

____ ____________________

Signature Date

☐ **I choose to apply for the sliding fee scale discount.** The sliding fee scale is available for all patients, regardless of insurance status. If you have insurance, the sliding fee scale discount can be applied to charges not covered by insurance. Please complete the entire form to determine eligible discount.

Household Members		NAME	BIRTHDATE (MM/DD/YYYY)	HEALTH INSURANCE	RELATIONSHIP	SEA MAR PATIENT?
	1					
	2					
	3					
	4					
	5					
	6					

SOURCE OF INCOME	ANNUAL INCOME	For You	For Spouse	For Children	For Others	Sub Total
	Gross Wages, Salaries, Tips					$
	Social Security & Pensions					$
	Annuity & Veteran Benefits					$
	Child Support & Alimony					$
	Self-Employment & Other					$
	"Other," please explain:					
					TOTAL	$

By signing below, I agree to provide Sea Mar Community Health Centers with a proof of income for all persons listed above. Acceptable proof of income includes, but is not limited to, social security statements, paycheck stubs (two most recent), public assistance letter, tax return form, W-2 form, L&I check stub, unemployment check stub.

I understand that I will be asked to reapply for the sliding fee scale at least once a year so Sea Mar can maintain an updated application on file. I certify that the information provided is accurate and complete to the best of my knowledge. I understand that if I knowingly give false information that results in assistance for which I am not eligible, I will be subject to criminal prosecution. I give my consent to release any and all information from whatever source needed to verify the information I have given.

____ ________________

Signature Date

OFFICE USE ONLY

Patient is eligible for Sliding Fee Scale: Yes No SFS Status (circle one): A B C D E F

POI Requested: ____________ Initial: ______ POI Received: ____________ Initial: ______