LAKE ALMANOR CLINIC
P.O. Box 1460/199 Reynolds Road, Chester, CA 96020
A Public Entity Providing Health Care Services

REGISTRATION FORM
DATE: ___________________
Social Security #: __________________________

Demographics

Legal Last Name:_____________________________ Legal First Name:____________________ Middle Name/Initial:__________

Former Last Name(s):_______________________________________ Birth Date:___________ Birth Place:_____________

Country of Residence:________________ Language:____________ Military: ☐ Active Duty ☐ Veteran ☐ N/A

Mailing Address:____ City:_________________________ State:_________ Zip:___

Physical Address:____ City:_________________________ State:_________ Zip:___

County:_______________ Home Phone:_________________ Cell Phone:___________________ Email:__________________

Gender Assigned at Birth:
☐ Male ☐ Female

Gender Identity:
☐ Male ☐ Female
☐ Transgender Man
☐ Transgender Female
☐ Other: ______
☐ Decline to Answer

Sexual Orientation:
☐ Lesbian/Gay/Homosexual
☐ Straight/Heterosexual
☐ Bisexual
☐ Something Else ☐ Don't Know

Race:
☐ Black ☐ Native American
☐ White ☐ Other ☐ Unknown

Ethnicity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Marital Status:
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Life Time Partner
☐ Widowed

Smokeless Tobacco:
Moist Powdered Tobacco/Snuff/Chew:
☐ Never ☐ Ex-User ☐ Current User

Smoking Status:
☐ Current Every Day Smoker
☐ Former Smoker ☐ Never Smoked
☐ Heavy Smoker ☐ Light Smoker

Tobacco Start Date:___________

Tobacco Stop Date:___________

Driver's License #:____________________ State of License:______ Occupation:____

Employer's Name:____ Employer's Phone:__________________

Employer's Mailing Address:____ City:_________________ State:_________ Zip:___

Employer's Physical Address:____ City:_________________ State:_________ Zip:___

Primary Care Physician: ______________Do you have an Advance Directive? ☐ Y☐ N If YES, what type:_______________

Emergency Contact's Name & Phone #:____ Relation:_________________

Billing Information/Primary Insurance

Person Financially Responsible for Charges (Guarantor):____________________________________ Phone:_______________

Guarantor's Mailing Address:____ City:_________________ State:_________ Zip:___

Insurance Company:_________________________________ Policy #:____________________ Group #:___________________

Subscriber's Name: ____Subscriber's Birth Date:________ Relation:_____________

Subscriber's Mailing Address:____ City:_________________ State:_________ Zip:___

Subscriber's Employment: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired (Date):_______ ☐ Active Military

Subscriber's Employer:____ Employer's Phone:__________________

Employer's Mailing Address:____ City:_________________ State:_________ Zip:___

Secondary Insurance

Insurance Company:_________________________________ Policy #:____________________ Group #:___________________

Subscriber's Name: ____Subscriber's Birth Date:________ Relation:_____________

Subscriber's Mailing Address:____ City:_________________ State:_________ Zip:___

Subscriber's Employment: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired (Date):_______ ☐ Active Military

Subscriber's Employer:____ Employer's Phone:__________________

Employer's Mailing Address:____ City:_________________ State:_________ Zip:___