LAKE ALMANOR CLINIC **REGISTRATION FORM**
P.O. Box 1460/199 Reynolds Road, Chester, CA 96020 **DATE: _____**
A Public Entity Providing Health Care Services 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:
☐ American Indian/Alaska Native
☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

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:___