United Health Centers of the San Joaquin Valley

Patient Information

First Name:	Last Name:	Preferred Language: ☐ Spanish ☐ English ☐ Other:_____
Home Address:	**Home Phone Number**:	
City: Zip Code:	**Cell Phone Number**:	**Social Security Number**:
Consent to Text: ☐ Yes ☐ No	Pharmacy:	Legal Gender ☐ Male ☐ Female Transgender ☐ Male->Female ☐ Female -> Male
Driver's License or State Id Number: State Issued:		
Date of Birth:	Preferred Contact Number ☐ Home ☐ Cell ☐ Work	**Email**:
Emergency Contact Name:	Number:	Relationship:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Veteran: ☐ Yes ☐ No
Race (Check all that apply) ☐ White ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ American Indian/ Alaskan Native ☐ Asian ☐ More than one race ☐ Decline to specify		
Ethnicity: ☐ Hispanic or Latino ☐ Asian ☐ Decline to specify ☐ Unknown		
Agricultural Worker: ☐ Yes ☐ No	Homeless: ☐ Yes ☐ No	Public Housing Recipient: ☐ Yes ☐ No
How many household members? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8		
Annual Income? ☐ $0 - $15,000 ☐ $15,001 - $30,000 ☐ $30,001 - $50,000 ☐ $50,001 - $100,000 ☐ $100,000+		

Parent/Guardian Name:	DOB:

Primary Insurance

Name of Insurance Company:	**Uninsured** ☐		Policy Number:
Name of Insured:	Date of Birth of Insured:		Group Number:
Address of Insurance Company:			City, State, Zip:
Phone:	Effective Date:	Expiration Date:	Relationship to Patient:

Signature of Patient Date