Father Joe's Villages
Village Health Center

Athena/Dentrix ID:

Registration Form

Name (Last, First)		**Gender** ☐ Male ☐ Female ☐ MF ☐ FM
Address (☐ Mail only)		**Date of Birth**
City	**State**	**Zip Code**
Phone Number (☐home ☐ cell)	**Social Security Number** (if have one)	**Email Address**
Parent Name (if patient is a minor)		**Parent Date of Birth** (if patient a minor)
Emergency Contact Name, Relationship, and Telephone Number		**Preferred Method of Contact** ☐ Home phone ☐ Cell ☐ Email

Race (check all that apply) ☐ American Indian ☐ Pacific Islander ☐ Asian ☐ Unknown ☐ Black or African American ☐ Decline to answer ☐ White ☐ Other: _____________	**Primary Language** ☐ English ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Tagalog ☐ Farsi ☐ Chinese ☐ Other _____________
Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____________ **Marital Status** ☐ Married ☐ Single ☐ Domestic Partner ☐ Widowed ☐ Separated ☐ Unknown ☐ Divorced	**Housing Status** ☐ Own or Rent ☐ No Permanent Housing (Homeless) *If you checked "No Permanent Housing", where are you currently staying?* ☐ RVs or Vehicle ☐ Shelter ☐ Doubling up with family/friends ☐ Migrant Camp ☐ Streets ☐ Transitional ☐ Other________________
Sexual Orientation ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Straight/heterosexual ☐ Don't know ☐ Choose not to disclose	**Agricultural worker:** ☐Yes ☐ No **School based Health Center:** ☐Yes ☐ No **Veteran:** ☐Yes ☐ No **Public Housing:** ☐Yes ☐ No
Family Size: ______________ **Monthly Income:** ___________	**Cstar ID:** _____________________ **Preferred Pharmacy:** _____________
Insurance Type ☐ Medicare ☐ VA ☐ Medi/Cal ☐ None ☐ Other:_____________	**Referring Program:** ________________________

I declare the above information is true. I understand that this information will be kept in strict confidence.

Patient Signature ____ Date ______________________________