HOPE MEDICAL CLINIC

Patient Registration

Record #	**Allergies**

IDENTIFYING INFO

Patient Name _____

LAST **FIRST** **MI**

Sex **M** **F** **DOB** _____ **SS#** _____

CONTACT INFO

Phone #: _____ **Email** _____

ADDRESS and EMERGENCY CONTACT

Address: _____

Street **City,State** **Zip**

Emergency Contact Person

Phone #: _____

DEMOGRAPHICS

Ethnicity: (please circle) **Hispanic** **Non-Hispanic**

Preferred Language _____

Race: (please circle) **Asian** **African American** **Caucasian**
Hispanic **Native American** **Other**

OTHER

How did you hear about the Clinic: _____ **Pregnant?** **yes** **no**
Medicaid? **yes** **no**

If patient is a child please print parent(s) name _____ **MAP?** **yes** **no**

CONSENT FOR TREATMENT: I hereby authorize HOPE MEDICAL CLINIC to perorm all medical treatment which may be deemed necessary or advisable. I also vertify that all the information I have provided is true and correct. I understand that I may receive services provided by students in multiple health professions who are under direct supervision by licensed medical professionals.

_____

Signature of Patient or Parent **Date**