



Welcome to San Ysidro Health

Financial Responsibility (Patient or Legal Guardian)

Please complete a registration form if you are a new San Ysidro Health patient or if you need to update your registration information. (You need an "Identification" card to register and other documents may be required)

Name _____ Nickname _____ Date of Birth _____

San Diego County/Southern California Address

Address _____ City _____ State _____ Zip Code _____

Other address

Address _____ City _____ State _____ Zip Code _____

Social Security # _____ Marital Status _____ Mother's Maiden Name _____

Home Phone _____ Cell # _____ Email address _____

May we send you SMS TEXT messages to remind you of upcoming appointments? Yes No if you agree, you will be responsible for providing current cell phone information. You may Opt-out from receiving TEXT messages at any time.

Birth Sex: Male Female **Current sex:** Male Female

Gender Identity: Male Female Transgender Male/F – M Transgender Female/M – F

Non-binary / Genderqueer Other Choose not to disclose

Sexual Orientation:

Straight (Not Lesbian/Gay) Lesbian or Gay Bisexual Something else Don't Know Choose not to disclose

Race: White Black/African-American Asian American Indian/Alaska Native Native Hawaiian
Pacific Islander Unreported Decline to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to specify Other Unknown

Children or Dependents Information

How many dependents? (Including yourself) _____

Name _____ Social Security # _____ Date of Birth _____ Gender: Male Female

Name _____ Social Security # _____ Date of Birth _____ Gender: Male Female

Name _____ Social Security # _____ Date of Birth _____ Gender: Male Female

Contact in Case of Emergency (Other than yours)

Name _____ Phone# _____ Relationship _____

Information:

Do you have a medical problem as a result of a work injury? Yes No Do you have a disability? Yes No

Do any of your dependents have a disability? Yes No Are you a Veteran Yes No

Are you living in Public Housing or receiving section 8? Yes No Are you comfortable speaking English? Yes No

Are you homeless or living in a shelter? Yes No Are you a Seasonal or Migrant worker? Yes No

Do you need assistance to pay for medical services? Yes No

What type of medical coverage do you have? Medi-Cal Medicare Covered California Other _____

Do you need your medical records to be transferred to San Ysidro Health? Yes No

What is your total household monthly income? \$ _____

Patient and/or Legal Guardian Signature _____ Date _____