Patient Label
For Office Use Only

Sycuan Medical Dental Center
Tel: (619) 445-0707
Website: https://www.sycuanmedicaldentalcenter.org

PATIENT REGISTRATION FORM

Patient Name: _____ Preferred Name: _____
Last *First* *M.I.*

Date of Birth: _____ Social Security #: _____

Mother's Maiden Name: _____ Preferred Language: _____

Religion: _____

Gender Identity: □ Male □ Female □ Transgender Female to Male
□ Transgender Male to Female □ Other □ Decline to Specify

Sexual Orientation: □ Lesbian/Gay □ Straight (not lesbian/gay) □ Bisexual
□ I Don't Know □ Something Else □ Decline to Specify

Preferred Pronoun: □ He, Him, His □ She, Her, Hers □ They, Them, Theirs
□ Decline to Answer □ Other

Address: _____ City: _____ State: _____ Zip: _____

Mailing: _____ City: _____ State: _____ Zip: _____
(If different from residence address)

Marital Status: □ Single □ Married □ Divorced □ Widowed

Home #: _____ Cell #: _____ Work #: _____

Alternate #: _____ Email Address: _____

Emergency Contact: _____ Contact Number: _____

Relationship to Patient: _____

5442 SYCUAN ROAD, EL CAJON, CA 92019
ADMIN OFFICE FAX (619) 445-9764 • DENTAL FAX (619) 445-5419 • MEDICAL FAX (619) 445-0988

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If the patient is a minor, please indicate Parent/Guardian's information:
Parent(s)/Guardian(s) Name:

_____

_____

Parent(s)/Guardian(s) Contact Numbers:

_____

_____

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Non-Latino □ Decline to Specify

Race: □ American Indian/Alaskan Native □ Native Hawaiian □ Other Pacific Islander

□ Asian □ Middle Eastern/North African □ Black/African American

□ White □ Other *(Please Specify)* _____

If American Indian/Alaskan Native, please provide your Tribal Affiliation card:

Tribal Enrollment #: _____ Community/Village of Residence: _____

Tribal Affiliation: _____ Other Tribal Affiliation: _____

Tribal Blood Quantum: _____ *(if applicable)*

Tribal Descendancy: □ Mother □ Father □Unknown

Are you currently employed? □ Yes □ No □ Retired

Name of Employer: _____ Department: _____

Occupation: _____ Address: _____

Gross Income: $_____ per year Number of People in Household: _____

Are you a U.S. Veteran? □ Yes □ No If yes, which branch? _____

Are you a Migrant Worker? □ Yes □ No

Homeless or living in a shelter? □ Yes □ No

Are you living in Public Housing or receiving Section 8? □ Yes □ No

FOR OFFICE USE ONLY:
Community Code: _____

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Primary Insurance: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Policy Holder Address: _____

Please list the name(s) of a person(s) with whom we can share the patient's Protected Health Information (PHI), and/or who can pick up prescriptions, in the event you are unable to:

*(If none, please write "**NONE**")*

_____

_____

_____

May we send you SMS Text messages or emails to remind you of your upcoming appointments and/or updates for SMDC? □ Yes □ No

If you agree, you will be responsible for providing your current cellphone number or email address. You may opt-out at any time.

I, as the patient or guardian, certify that the information I am providing to Sycuan Medical Dental Center is true and accurate. I acknowledge that I am financially responsible for payment, whether or not covered by insurance.

Patient Signature: _____ Date: _____

Representative Signature: _____ Date: _____

If signed by someone other than the patient, please specify the relationship to the patient:

_____

FOR OFFICE USE ONLY:

Intake by: _____ Date Scanned on Patient's Chart: _____