AXIS Health System

PATIENT REGISTRATION (Please complete electronically or in blue or black ink.)

Parent/Guardian: Please fill this out as if you are answering for the patient.							
Last Name		**First Name**		**Middle Name**		**Preferred Name**	
SSN		**DOB**		**Sex on file with insurance provider**	☐ Male ☐ Female ☐ X		
Gender	☐ Female ☐ Male	☐ Non-Binary ☐ Transgender Female ☐ Transgender Male		☐ Choose not to disclose ☐ Unknown ☐ Other _____			
Sexual Orientation	☐ Asexual ☐ Bisexual ☐ Gay or Lesbian	☐ Heterosexual or Straight ☐ Pansexual		☐ Choose not to disclose ☐ Unknown ☐ Other _____			
Pronoun	☐ He, Him ☐ She, Her ☐ They, Them	☐ Hir, Hirs, (pronounced 'here') ☐ Ze, Zie (pronounced 'zee')		☐ Prefer using my name only ☐ Other_____			
Billing Address		**City**		**State**		**Postal Code**	
Physical Address		**City**		**State**		**Postal Code**	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed ☐ Other_____			**Student Status**	☐ Full-time Student ☐ Part-time Student ☐ Not a Student		
Race	☐ African American/Black ☐ Alaskan Native ☐ Asian Indian ☐ Caucasian/White ☐ Chinese ☐ Filipino	☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian		☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ Choose not to disclose ☐ American Indian Tribal Affiliation(s) _____			
Ethnicity	☐ Choose not to disclose ☐ Cuban ☐ Mexican, Mexican American, Chicano/a	☐ Puerto Rican ☐ Not Hispanic, Latino/a/x, or Spanish Origin ☐ Another Hispanic Latino/a/x, or Spanish Origin				**Preferred Language**	
Primary Care Provider				**Dental Care Provider**			
Day Phone		**Cellular Phone**				**Home Phone**	
Email Address				**Housing Status**	☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional ☐ Not Homeless ☐ Unknown		
Migrant Worker Status	☐ Migrant ☐ Seasonal ☐ Not a Farm Worker	**Have you served in the United States military, armed forces, or uniformed services?** ☐ Yes ☐ No		**Preferred Pharmacy**			
Emergency Contact Name			**Emergency Contact Phone**			**Relationship to Patient**	
Minors:							
Parent/Guardian Name		**Relationship to Patient**		**Custodial Responsibility**			
How did you hear about us?	☐ Website ☐ Friend / Family	☐ Poster ☐ Provider Referral	☐ Social Media	☐ Newspaper ☐ Radio	☐ Google Search ☐ Email ☐ Postcard		

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____