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| Client Label | County of Orange, CaliforniaHealth Care Agency17th Street Testing and Treatment |
| ALL INFORMATION ON THIS FORM IS CONFIDENTIALCONFIDENTIAL CLIENT INFORMATION CIVIL CODE 56.10**PATIENT REGISTRATION FORM** |

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| --- | --- | --- | --- | --- | --- |
| **Last Name** |  | **First Name** |  | **Middle Name** |  |
|  |  |  |  |  |  |
| **Date of Birth**  | **(MM** | **Gender** | [ ]  Female [ ]  Male [ ]  Transgender M to F [ ]  Transgender F to M  |
|  |  |  |  |  |
| **Street Address** |  | **City** |  |
|  |  |  |  |
| **Zip Code** |  | **Telephone Number** | **( )** | **Email** |  |
|  |  |  |  |  |
| **Place of Birth** |  | **Mother’s Maiden Name** |  |

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| --- | --- |
| **Hispanic**  | [ ]  Yes [ ]  No [ ]  Unknown |
| **Ethnicity** |  |
| [ ]  Aleut[ ]  Algerian[ ]  American Indian [ ]  Black/African American[ ]  Cambodian[ ]  Caucasian/White [ ]  Chinese[ ]  Cuban[ ]  Egyptian | [ ]  Eskimo [ ]  Filipino [ ]  Guamanian [ ]  Hawaiian Native[ ]  Hispanic-Other [ ]  Indian (Asian)[ ]  Iranian[ ]  Iraqi[ ]  Japanese | [ ]  Korean[ ]  Laotian [ ]  Lebanese[ ]  Mexican[ ]  Native American /American Indian[ ]  Pacific Islander [ ]  Palestinian[ ]  Puerto Rican | [ ]  Samoan[ ]  Somalian[ ]  South/Central American [ ]  Spanish[ ]  Thai [ ]  Vietnamese [ ]  Withheld[ ]  Unknown[ ]  Other\_\_\_\_\_\_\_\_­­\_\_\_\_ |
| **Race** |  |
| [ ]  Alaskan Native[ ]  American Indian | [ ]  Asian[ ]  Black  | [ ]  Pacific Islander[ ]  White  | [ ]  Unknown[ ]  Other\_\_\_\_\_\_\_\_­­\_\_\_\_ |
| **Primary Language** |  |
| [ ]  Am. Sign Language[ ]  Arabic[ ]  Armenian[ ]  Cambodian[ ]  Cantonese[ ]  English[ ]  Farsi[ ]  French | [ ]  German [ ]  Greek[ ]  Hebrew[ ]  Hindi[ ]  Hmong[ ]  Italian[ ]  Japanese[ ]  Korean | [ ]  Lao[ ]  Mandarin [ ]  Mien[ ]  Persian[ ]  Polish[ ]  Portuguese[ ]  Romanian[ ]  Russian | [ ]  Samoan[ ]  Spanish [ ]  Tagalog[ ]  Thai[ ]  Turkish[ ]  Vietnamese[ ]  Other\_\_\_\_\_\_\_\_­­\_\_\_\_ |
|  |  |  |  |  |

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| --- |
| **Emergency Contact**  |
|  |  |  |  |  |
| **Last Name** |  | **First Name** |  | **Telephone**  | **( )** |

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| --- |
| **I herby give permission to County of Orange Health Care Agency physicians, nurses, medical practitioners and personnel in medical training to perform examinations, tests and treatments upon myself as recommended and explained to me by public health personnel.** |
| Client Signature |  | Date  |  |

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**In order for us to better serve you, please check the reason(s) you came in today. It is important to be honest and complete with these answers so that we can insure that you receive the highest quality of service.**

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| --- | --- |
| [ ]  First STD Visit | [ ]  Treatment |
|  |  |
| [ ]  Results | [ ]  Hepatitis Vaccine |
|  |  |
| [ ]  STD Check-up | [ ]  Counselor/Questions |
|  |  |
| [ ]  My partner/I had contact with STD (Sexually Transmitted Disease) |
|  |
| [ ]  Notified by a Public Health Representative |
|  |
| [ ]  Notified by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to come to clinic |
|  |
| [ ]  I received a telephone call or letter to come in to clinic  |

**Are you having any of the following symptoms today (check all that apply)?**

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| [ ]  No, I have no symptoms today. I just want to get checked. |
|  |  |
| [ ]  Abdominal pain | [ ]  Sore throat/Swollen glands  |
|  |  |
| [ ]  Bleeding between periods | [ ]  Sore/Lesion  |
|  |  |
| [ ]  Burning with urination  | [ ]  Testicular pain |
|  |  |
| [ ]  Itching | [ ]  Vaginal discharge/Pain  |
|  |  |
| [ ]  Rash  | [ ]  Vaginal odor |
|  |  |
| [ ]  Rectal discharge/Pain | [ ]  Warts/Bumps |