

|  |  |
| --- | --- |
| Client Label | County of Orange, California  Health Care Agency  17th Street Testing and Treatment |
| ALL INFORMATION ON THIS FORM IS CONFIDENTIAL  CONFIDENTIAL CLIENT INFORMATION CIVIL CODE 56.10  **PATIENT REGISTRATION FORM** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | |  | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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\_\_\_\_\_\_\_\_­­\_\_\_\_ |
|  |  |  | | |  |  | |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |

|  |  |
| --- | --- |
| Client Label | county_bwCounty of Orange, California  Health Care Agency  17th Street Testing and Treatment |
| ALL INFORMATION ON THIS FORM IS CONFIDENTIAL  CONFIDENTIAL CLIENT INFORMATION CIVIL CODE 56.10  **PATIENT REGISTRATION FORM** |

**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.**

|  |  |
| --- | --- |
| 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)?**

|  |  |
| --- | --- |
| 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 |