Client Label
(*Clinic use only-Leave Blank)*

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

Complete the entire form, all fields are required.

Patient Information

Last Name _____ Address _____

First Name _____ City _____ Zip _____

Middle Name _____ Mail Ok? ☐ Yes ☐ No

Preferred Name _____ Telephone Number _____

Date of Birth _____ Messages Ok? ☐ Yes ☐ No

Gender ☐ Female ☐ Male ☐ Transgender Female Email _____

☐ Transgender Male ☐ Declined to State Place of Birth _____

☐ Genderqueer or Non-Binary Mother's Maiden Name _____

☐ Other _____

Gender Pronouns ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Hispanic	☐ Yes ☐ No ☐ Unknown		
Ethnicity	☐ Black/African American ☐ Cambodian ☐ Caucasian/European/White ☐ Chinese ☐ Cuban ☐ Egyptian ☐ Filipino ☐ Guamanian ☐ Hawaiian Native	☐ Hispanic-Other ☐ Indian (Asian) ☐ Iranian ☐ Japanese ☐ Korean ☐ Laotian ☐ Lebanese ☐ Mexican ☐ Native American /Am Indian	☐ Pacific Islander-No Haw/Guam/ Sam ☐ Puerto Rican ☐ Samoan ☐ South or Central American ☐ Spanish ☐ Thai ☐ Vietnamese ☐ Other_____
Race	☐ Alaskan Native ☐ American Indian ☐ Asian	☐ Black ☐ Pacific Islander ☐ White	☐ Unknown ☐ Other_____
Primary Language	☐ Arabic ☐ Cambodian ☐ Cantonese ☐ English ☐ Farsi ☐ French ☐ German	☐ Indian ☐ Japanese ☐ Korean ☐ Mandarin ☐ Persian ☐ Portuguese ☐ Spanish	☐ Tagalog ☐ Thai ☐ Vietnamese ☐ Withheld ☐ Other Sign Language ☐ Other_____

Emergency Contact

Last Name _____ First Name _____ Telephone _____