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 ______________________ First Name ____________________ Middle Name _____________

Preferred name (also known as) __________________________________ Date of Birth _______________

Gender ☐ Female ☐ Male ☐ Transgender F to M ☐ Transgender M to F ☐ Declined to State ☐ Other

Street Address ____ City ____________________

Zip Code _____________ Telephone Number ______________________ Email ___________________

Place of Birth ____________________________ Mother's Maiden Name ___________________________

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 ________________