Southern Dominion Health System, Inc.

PATIENT REGISTRATION FORM
Please Fill In All Information

PATIENT INFORMATION (PLEASE PRINT)

Date of Birth: | **Social Security Number:**

Patient's Last name: **First:** **Middle:**

Marital status: ❑Single ❑Married ❑Divorced ❑ Separated ❑Widow

Mother's Maiden Name: **Are you a Veteran:** ❑ Yes ❑ No

Race: ❑ Asian ❑ Black/African American ❑ Caucasian(White) ❑ Other Pacific Islander ❑ American Indian/Alaska Native

Pharmacy:

Sex: ❑ M ❑ F

Ethnicity: ❑ Hispanic/Latina(o) ❑ Non-Hispanic/Latina(o) ❑Refuse to Report ❑ Other

Secondary:

Mailing Address: **Email Address:**

City: **State:** **ZIP Code:** **Home Phone Number:** ( )

Preferred Method of Contact: ❑ Voice Call: ❑cell ❑home ❑ Text ❑ Email
Do you have Internet Access: ❑ Yes ❑ No

Cellular Phone Number: ( )

Is the patient : ❑Employed ❑Unemployed ❑Retired ❑Self-Employed ❑Disabled
❑In school: ❑Full time or ❑Part time
Name of Employer:_____
Address:_____
_____
Phone: _____

Preferred SDHS Provider:

Primary Care Physician:

Native Language: ❑ English ❑ Spanish ❑ Other, please list:_____

If under 18, Parent/Guardian/Guarantor Name: | **Parent/Guardian/Guarantor Employer:** | **Employer phone number:** ( )

Parents/Guardians/Guarantor Address, City, State, Zip: **Birthdate:** **SS#** **Phone #**

EMERGENCY CONTACT, IN CASE OF EMERGENCY NAME OF PERSON WE CAN CONTACT:

NAME:
PHONE NUMBER:
RELATIONSHIP TO PATIENT: ❑ Spouse ❑ Child ❑ Parent ❑ Other_____

Income Verification: (*As a Federally Qualified Health Center, we are required to ask this information for reporting purposes).*

Please check the box that pertains your family's annual income.

❑ Greater than $50,000 ❑ $35,000-49,999 ❑ $25,000-34,999

❑ $15,000-24,999 ❑ $10,000-14,999 ❑ Less than $10,000

Number of household members supported by this income: _____