Oneida County Health Department- Reproductive Health Clinic

REGISTRATION FORM

Preferred Name: _____

Legal Last Name: _____

Legal First Name: _____

Middle Initial: _____

Maiden Name: _____

Social Security #:_____

US Citizen? □ Yes □ No

Live in WI? □ Yes □ No

Gender: □ Female □ Male

□ Other: specify; _____

□ Transgender-Female to Male

□ Transgender-Male to Female

Date of Birth:_____/_____/_____
(Month) (day) (year)

Age: _____

Ethnicity: □ **H**ispanic/Latino □ **N**on-**H**ispanic

□ **U**nknown/Other: _____

Race: □ Am. **I**ndian □ **W**hite

□ **A**sian □ **U**nknown

□ **B**lack

□ Hawaiian/**P**acific Islander

Can we send you mail? □ No □ Yes

□ Yes, plain envelope

Home Address:

Street:_____

City:_____ State:_____ Zip code:_____

County:_____

Do you get mail at above address? If not, where do you get mail?

Address: _____

City: _____ State: _____ Zip code: _____

When we contact you, can we say "Reproductive Health Clinic"? □ Yes □ No

Phone: Cell Phone: _____

Home Phone: _____

Preference: How do you prefer we contact you? □ cell phone □ home phone □ text message

Alternate Contact:

Name: _____ Relationship: _____

Phone: _____

Street/Mailing Address: _____

City: _____ State: _____ Zip code: _____

How did you hear about our services?:

(circle all that apply): Friends/Family PNCC WIC TriCoDVSA School Clinic Website Employer Nicolet College Other:_____

(Please complete the other side and sign)

For Staff USE ONLY: Client Number:_____

Initials of Staff _____ DATE:____/_____/_____ Discount Level:_____

Notes:_____

_____

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Medical Health Care Coverage:

Do you have health insurance or Medicaid? □ NO □ Yes

If yes, coverage type:
- □ Public (Badgercare, FPOS, SSI, etc)
- □ Private Health Insurance _____
- □ Unknown
- □ Other:_____

Medical Needs:

Do you have a Primary Care Provider? □ NO □ Yes

If yes, name of Primary Care Provider or Clinic:_____

Do you have a chronic medical, behavorial, emotional or other health condition that has lasted or is expected to last 12 months? □ No □ Yes

If yes, what is it?:_____

Education:

Highest level of education received:
- □ less than 9th grade
- □ 9th-12th grade- No diploma -Highest Grade completed:_____
- □ High School Graduate
- □ Some college- No degree -Highest Grade completed:_____
- □ Associates Degree
- □ Bachelor's Degree
- □ Graduate or Professional Degree

Marital status: □ Married □ Unknown □ Never Married (single) □ Separated □ Divorced □ Widow

Income Information:

Are you employed? □ NO □ Yes

If yes, how many hours per week?_____ Hourly rate:_____

Spouse hours worked per week?_____ Hourly rate:_____

Types of Other Income:

□ Allowances/Parents	Approximate amount?_____	per month.
□ Disability	Approximate amount?_____	per month.
□ Social Security (SSI)	Approximate amount?_____	per month.
□ Unemployment	Approximate amount?_____	per month.
□ Trust Fund	Approximate amount?_____	per month.
□ Alimony/Child support	Approximate amount?_____	per month.
□ Grants/Other:_____	Approximate amount?_____	per month.
	Total Earned income:	**per month.**

Number of family members supported by income(s):_____

Office Use ONLY:

Health Care Services Charged to:
FPOS
BC
Private Ins.
Pts/Parents
Other
Unknown

Primary Care:
PCPY
PCPN

Sp. Health Care Needs
SHCY
SHCN

Confidential:
CSDY
CSDN

I hereby certify, under penalty of law, that this information is accurate and complete.
If my income changes, I agree to notify OCHD-Reproductive Health Clinic at my next visit.

Signature:_____ **Date:**_____

All Services are confidential.