Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

Pediatric Patient Registration

Chart No:_____

Please answer all questions to the best of your ability. Your answers are confidential. Camino Health Center utilizes the information you provide to continuously evaluate existing programs and services. Additionally, Camino Health Center receives grant funding which requires the heath center to provide statistics on its patient population. If you have any questions about this registration form, please ask a Patient Services Representative at the front desk for assistance.

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth	
Address	City		State	Zip

Child's Birth Weight: _____lbs _____oz	SSN	Email Address
Please check primary phone	Cell Phone ☐ ( )	Home Phone ☐ ( )
Sex at Birth: ☐ Male ☐ Female	Were there any health problems immediately after birth? ☐ Yes ☐ No Please explain: _____	
Primary Language: _____	Do you need an interpreter: ☐ Yes ☐ No	

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race:

☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Other Multi-Racial
☐ Other Pacific Islander
☐ White/Caucasian (Hispanic/Latino)

Patient's Gender Identity:

☐ Male
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Choose not to disclose

Patient's Sexual Orientation:

☐ Straight/heterosexual
☐ Lesbian, gay or homosexual
☐ Bisexual
☐ Something else/other
☐ Don't Know
☐ Choose not to disclose

Father's Name: _____	Mother's Name: _____

Are you homeless: ☐ Yes ☐ No	Have you ever been concerned of running out of food: ☐ Yes ☐ No	Are any members of your family migrant farm workers: ☐ Yes ☐ No

Do you have any psychological, spiritual or cultural values that will assist us in your treatment: ☐ Yes ☐ No	Do you have an Advance Health Care Directive: ☐ Yes ☐ No

RESPONSIBLE PARTY (GUARANTOR)

Last Name	First Name	MI	Date of Birth	
Address	City		State	Zip

Please check primary phone	Cell Phone ☐ ( )	Work Phone ☐ ( )	Home Phone ☐ ( )
Relationship to Patient: _____		Preferred Language: _____	

EMERGENCY CONTACT

Last Name	First Name	MI	Contact Phone Number: ( )	
Address	City		State	Zip

Relationship to Patient: _____

Patient Signature: _____ Date: _____