Patient Label
For Office Use Only

Sycuan Medical Dental Center
Tel: (619) 445-0707
Website: https://www.sycuanmedicaldentalcenter.org

PATIENT REGISTRATION FORM

Patient Name: ____________________ ____________________ __________ Date of Birth: ____/____/_____
Print As on ID *Last* *First* *Middle Initial*

Preferred Name: ______________________________ Mother's Maiden Name: ____________________

Social Security #: _______-_____-________ Preferred Language: ______________________

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

Contact Information

Home: ______________ Cell: ______________ Work: ______________x____ Email: __________________

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work ☐ Email

Text/Email Appointment Reminder: ☐ Yes ☐ No

Address: ________________________________ #______ City: _______________ State: _____ Zip: ______

Mailing: ________________________________ #______ City: _______________ State: _____ Zip: ______

Sexual Orientation and Gender Identity (SOGI)

Gender Identity: ☐ Male ☐ Transgender Male to Female ☐ Decline to Specify
☐ Female ☐ Transgender Female to Male ☐ Other (Please Specify) _________

Preferred Pronoun: ☐ He, Him, His ☐ Decline to Specify
☐ She, Her, Hers ☐ Something Else (Please Specify) ____________
☐ They, Them, Theirs

Sexual Orientation: ☐ Straight ☐ I Do Not Know
☐ Lesbian ☐ Something Else (Please Specify) ____________
☐ Bisexual ☐ Decline to Specify

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to Specify

Race: ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian
☐ Other Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian
☐ White ☐ Other (Please Specify) ☐ Decline to Specify

Insurance Information

Primary Insurance: ____________________________ ID #:_________________ Group #:______________

Policy Holder Name: _________________________ DOB: _______________ SSN #:______-____-______

Secondary Insurance: __________________________ ID #:________________ Group #:______________

Policy Holder Name: _________________________ DOB: _______________ SSN #:______-____-______

Policy Holder Address: ____

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If the Patient is a minor, please provide the parent/legal Guardian's information.

Parent/Legal Guardian Name: ________________________________ Phone: ______________________

Relationship to Patient: _____________________________________

Parent/Legal Guardian Name: ________________________________ Phone: ______________________

Relationship to Patient: ___________________________________

Tribal Affiliation

If American Indian/Alaskan Native, please provide your Tribal Affiliation Card:

Tribal Enrollment #: ________________________________ Tribal Affiliation: ____________________

Community/Village of Residence: ______________________ Other Tribal Affiliation: _______________

Tribal Descendancy: ☐ Mother ☐ Father ☐ Unknown ☐ Tribal Blood Quantum: __________________

Work Status

Are you currently employed? ☐ Yes ☐ Retired ☐ No ☐ Student

If Employed: ☐ Full-Time ☐ Part-Time *If Student:* ☐ Full-Time ☐ Part-Time

Name of Employer: ________________________________ Department: _______________________

Occupation: __________________________ Address: ______________________________________

Gross Income: $__________________ per year ☐ Decline to Specify

Veteran/Military Status

Are you a US Veteran? ☐ Yes ☐ No If yes, which branch? ____________________________

Are you a Migrant Worker? ☐ Yes ☐ No Homeless or living in a shelter? ☐ Yes ☐ No

Are you living in Public Housing or receiving Section 8? ☐ Yes ☐ No

Preferred Pharmacy

Primary Pharmacy Name: ___________________________________ Phone: ______________________

Address: _____________________________ City: ________________ State: ________ Zip: _________

Secondary Pharmacy Name: _________________________________ Phone: ______________________

Address: _____________________________ City: ________________ State: ________ Zip: _________

Emergency Contact

Full Name: ______________________ Relationship: _________________ Phone #: _______________

As the Patient or Guardian, I certify that the information I am providing to Sycuan Medical Dental Center is true and accurate.

Patient Signature: ____ Date: __________________

Legal Representative Signature: ______________________________ Date: __________________

If signed by someone other than the patient, please specify the relation to the Patient: ____________________

FOR OFFICE USE ONLY:

Intake by: ___________________________ Date Scanned on Patient's Chart: _________________