Demographic Information

H - _____

Last Name	First Name	Middle Initial	Maiden/Other Last Name

Physical Address:	City	State	Zip Code
Mailing Address if PO Box:			

Home Phone	May we call you at this number? ☐ Yes ☐ No	Alternate Phone	May we call you at this number? ☐ Yes ☐ No

Social Security Number (Optional)	Sex ☐ Female ☐ Male	Date of Birth (mm/dd/ccyy)

Religious Preference	Country of Birth	Date Entered United States (mm/ccyy)

Do you have permanent housing (Renting a house or apartment is considered permanent)?	☐ Yes ☐ No

Race / Ethnicity / Language / Military Status

Race (Please check **all** that apply)

☐ Asian (A) ☐ Black or African American (B) ☐ Native American or Alaskan Native (N) ☐ Pacific Islander or Hawaiian Native (P) ☐ White / Caucasian (W) ☐ Decline to Answer (D)

Ethnicity (Please check one) ☐ Hispanic / Latino ☐ Non – Hispanic / Latino ☐ Decline to Answer

Do you need an interpreter? ☐ Yes If Yes, what is your primary language? _____ ☐ No

Have you ever served in the US Military? ☐ Yes ☐ No ☐ Decline to Answer

Income: Indicate income from **ALL FAMILY/HOUSEHOLD MEMBERS** before taxes (Not applicable for Travel Services): (This information is used to calculate discounted fees)
Salary/Wages, DSHS/Welfare Checks, Social Security/SSI, Unemployment, Child Support, etc. $_____/month

How many people are supported on this income? _____

Insurance Information

Do you have any type of medical or dental insurance coverage: Medicaid coupons, Take Charge, Healthy Options, Basic Health Plan, BHP Plus, CHIP, Commercial Insurance (not applicable for immunization only visits), Medicare, Other

☐ Yes (please show your medical coupon / insurance card at check-in) ☐ No

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the medical provider. I am financially responsible for any balance due. I authorize the medical provider or Insurance Company to release any information required for this claim. I certify that the above information is accurate, to the best of my knowledge.

Consent for Treatment: I hereby grant permission to Public Health-Seattle & King County to perform such medical/dental procedures as may be professionally deemed necessary or advisable for my diagnosis and treatment. In the event that the patient named above is an adolescent (13-17 years of age) requesting general medical/dental services, consent is specifically given for care when the said adolescent presents him/herself for treatment in my absence.

Signature _____ **Date** _____ **Relationship to patient** _____

CONTINUED ON BACK

*** This is a permanent part of the health record ***

Consent: Client Registration for Treatment

Public Health
Seattle & King County

Public Health – Seattle & King County
401 Fifth Avenue, Suite 1300
Seattle, WA 98104
Phone: 206-296-4600
Fax: 206-296-0166

Client Name: _____

HR #: _____

D.O.B.: _____

Distribution: White – Health Records

Emergency Contact Information

Last Name	First Name	Relationship to Patient
Home Phone	Alternate Phone	

Second Emergency Contact Information

Last Name	First Name	Relationship to Patient
Home Phone	Alternate Phone	

Employment Information

Occupation		Employer's Name	
Address	City	State	Zip Code
Work Phone	May we call you at this number? ☐ Yes ☐ No		

Do Not Complete the Information below if you are an adolescent (13-17 years) requesting confidential services.

Parent/Guardian Information – (Required for clients under 18 years of age)

Last Name	First Name		Relationship to Patient
Address (if different from patient)	City	State	Zip Code
Home Phone	May we call you at this number? ☐ Yes ☐ No	Alternate Phone	May we call you at this number? ☐ Yes ☐ No

Other Parent/Guardian Information – (If Applicable)

Last Name	First Name		Relationship to Patient
Address (if different from patient)	City	State	Zip Code
Home Phone	May we call you at this number? ☐ Yes ☐ No	Alternate Phone	May we call you at this number? ☐ Yes ☐ No

Citizenship Information – (*Required only for Refugee Screening or Civil Surgeon Programs*)

Alien #	Date of Arrival: _____/_____/_____ Month Day Year

*** This is a permanent part of the health record ***