



Client Registration Sign In Sheet

MRN: _____

Who are you seeing today? Care Manager Doctor Group Nurse Nurse Practitioner Therapist Other

What time is your appointment today? _____ A.M or P.M

Date: _____ Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Mobile Home Work

Consent for us to contact you by phone? Yes No Consent to leave a voicemail? Yes No Text Message? Yes No

Email: _____

Please circle below if any changed:

Has your Insurance Coverage or Income changed in the last 30 days? Yes No

Primary Care Doctor: _____ Did it change from your last visit? Yes No

Pharmacy: _____ Did it change from your last visit? Yes No

Please CHECK Yes or No

Are you a new patient?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Living in a group home or transitional housing?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you a Veteran?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Staying in temporary housing such as a hotel, motel, campground?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Living on the Street/Abandoned housing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Staying on a couch or other "bed" with friends?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Living in a women's shelter?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Living with family or friends and not on the lease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Living in a homeless shelter?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Living in unstable housing or just got housing in the past 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Living in public housing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	A seasonal agricultural worker at any time during the past 2 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How did you hear about us? <input type="checkbox"/> Flyer <input type="checkbox"/> Billboard <input type="checkbox"/> Email <input type="checkbox"/> Referral <input type="checkbox"/> Online Ad <input type="checkbox"/> Newspaper <input type="checkbox"/> Social Media <input type="checkbox"/> Family Member/Friend			