CLEAR PRINT

De Anza College Student Health Services
Patient Registration Form

Please print clearly and use PEN only.

Last Name:		First Name:	
Birth Date:	(MM/DD/YY)	Student ID #:	
Gender Identity:		Marital Status:	
Best phone # to call you:			
Alternate phone #:			
Email Address:			
Is it OK to send you confidential medical information / appointment reminders via e-mail?		◯Y / N◯	
Home Address:			
City/ State / Zip:			
Ethnicity (check one)	☐Hispanic/Latino ☐Non-Hispanic/Non-Latino		
Race (Check all that apply)	☐African-American ☐American Indian/Alaska Native ☐Asian ☐Pacific Islander ☐White ☐Other: _____		

Emergency Contact

Emergency Contact Name:	
Relationship:	
Contact Number:	

Miscellaneous

Do you have health insurance?	☐Yes: _____ ☐No If marked no, would you like more information on Covered California? ◯Y/ N◯
Primary Care Provider Info: (if known)	Physician Name: _____ Phone# _____
Languages Preferred:	

I certify that the information I have given on this form is complete and accurate.

Patient Signature:	Date:	Staff Signature:	Date: