Butte County Public Health Department Clinic

Date: _____ **Soc. Sec #:** _____ **Birth Date:** _____

Name: _____
Last Name First Name Middle Initial

Name at birth if different: _____

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

Mailing Address (if different from above)**:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email: _____ **Mother's first name:** _____

You may be contacted via the following methods, unless you OPT OUT by initialing the option(s) below:
Text _____ (initial) Email _____ (initial) Phone _____ (initial) Mail _____ (initial)

Birth Sex: _____ **Gender Identity:** _____ **Sexual Orientation:** _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Partnered

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian**/**Pacific Islander
❑ Hispanic ❑ White ❑ Other: _____ ❑ Decline to State

Ethnicity (check one)**:** ❑Non-Hispanic ❑ Hispanic **Spoken Language:** _____

Migrant: Y N **Homeless:** Y N **Disabilities:** Y N **Immigrant:** Y N **Seasonal:** Y N

Student (circle one)**:** Full-time Part-time Not a Student

Employer: _____ **Occupation:** _____

Family Size in the household: _____ **Gross Monthly Income:** $_____

In case of Emergency Notify (name)**:** _____ **Relationship:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Insurance (check all that applies)**:** ❑ MEDI-CAL ❑ FAMILY PACT ❑ MEDI-CARE ❑ PRIVATE INSURANCE

Insurance / Member ID #: _____ ❑ NO INSURANCE

Is this your first visit to the clinic? ❑ No ❑ Yes

Please tell us how you learned of our services….

❑ Friends / Family ❑ Employer ❑ Teacher / Counselor ❑ Caseworker / Doctor ❑ Website

❑ Newspaper ❑ Saw a Brochure / Flyer ❑ Other (please describe): _____

The above information is true to the best of my knowledge. I hereby give my consent to any and all services ordered by the attending clinicians for myself or my family member listed above.

- I agree not to hold the Butte County Department of Public Health, or any of its employees, liable for any act or omission in following their instructions.
- I consent to communication from Public Health to the above listed numbers, email and address unless otherwise noted above.
- I hereby authorize my insurance to pay benefits to which I am entitled directly to Butte County.
- I accept responsibility for payment of services not covered by my insurance and authorize the mailing of bills for such services to the address indicated above.
- I understand that other departments within the Butte County Public Health may access my medical record and share my immunization records with schools, hospitals, daycare's and other County Health Departments.
- I understand that confidentiality will be maintained except in cases of abuse or sexual assault.

X_____ _____
Client Signature / Legal Guardian **Date** Staff Signature Date

Relationship if not signed by patient _____