Maricopa County
Public Health
WeArePublicHealth.org

Date: ____________________

ECW No.: ____________________

PATIENT REGISTRATION

Please print clearly and complete all information

I. Patient Information - All Patients

PATIENT NAME (LAST -- FIRST -- MIDDLE NAME)

HOME ADDRESS	APT/LOT #	CITY, STATE	ZIP

PREFERRED METHOD OF COMMUNICATION: ❑ Email ❑ Home Phone ❑ Cell Phone	HOME PHONE	CELL PHONE

PATIENT DATE OF BIRTH (MM/DD/YYYY)	SEX ❑ Male ❑ Female ❑ Transgender

HAVE YOU BEEN SEEN AT THIS CLINIC BEFORE? ❑ Yes ❑ No

HAVE YOU EVER REGISTERED HERE USING A DIFFERENT FIRST/LAST NAME? ❑ Yes ❑ No Other Name:

ETHNICITY: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	RACE (Choose all that apply) : ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White

PROVIDE EMAIL ADDRESS IF YOU WOULD LIKE TO SET UP YOUR ELECTRONIC MEDICAL RECORDS ACCOUNT:

II. For Patients Requesting STD/HIV Services

This Clinic ***only* provides ***testing*** for Chlamydia, Gonorrhea, Syphilis, &HIV and ***treats*** for Chlamydia, Gonorrhea, and Syphilis ***only***. For all other infections, please ask for a list of low cost clinics.

PLEASE CHOOSE FROM THE OPTIONS BELOW BY CHECKING ONE OF THE BOXES:

❑ OPTION 1 - EXPRESS TESTING	❑ OPTION 2 - INTAKE VISIT	❑ OPTION 3 - RAPID HIV TESTING ONLY
You will be asked for blood and urine samples. You will be tested for Chlamydia, Gonorrhea, Syphilis and Rapid HIV. This is the best option if: • You have no symptoms; • You have NOT been told by a doctor or Public Health staff to come in for treatment.	You will be asked some questions and a decision will be made if you need to see a medical provider or if Option 1 is more appropriate for you. This is the best option if: • You are having symptoms of an STD (such as a sore or rash) or you have had sex with someone who had symptoms of an STD; • You have been told by a doctor or Public Health staff to come in.	• This option does not include testing for Chlamydia, Gonorrhea or Syphilis.

III. Acknowledgement - All Patients

I do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the medical providers and staff of the Maricopa County Department of Public Health to me or to the above-named minor of whom I am the parent or legal guardian.

________ My initials confirm that I understand that I will not get a refund if I refuse services once I have been seen in the clinic by a staff person.

________ My initials confirm that I understand that the name and date of birth on this form must match exactly with a valid, picture ID card before any test results or records will be released.

To the best of my knowledge, the information provided here is true and factual.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	Date
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	Date