Family HealthCare Network **COVID Pre-Registration**

Account #:

First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip Code
Physical Address (if different)	City	State	Zip Code
Home Phone ( )		Cell Phone ( )	
For the purposes of sending you health care minders: Okay to receive phone calls? ☐Yes ☐No		Okay to receive text messages? ☐Yes ☐No	
E-mail address:	Sex Assigned at Birth: ☐Male ☐Female	Birth Date (Month/Day/Year) / /	
What language do you feel most comfortable using? ☐English ☐Spanish ☐Other: _____			
Responsible Person (Parent or Legal Guardian signing this form) First Name: Last Name: Mailing Address (if different than above): City/State/Zip: Phone: ( ) Relationship to Patient:			
Ethnicity: ☐ Hispanic or Latino ☐Non-Hispanic or Latino			
Which of the following groups do you feel you belong to (select one or more than one): ☐African American ☐Asian ☐Native American/Alaskan ☐Native Hawaiian ☐Pacific Islander ☐White (includes Hispanic, Latino and European Middle Easter origin ☐More than One Race			
Experience with Agriculture (Farm Work) 1. In the last 2 years, have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, preparing the soil, packing house, dairy, driving a truck for any type of farm work, etc. ☐Yes ☐No 2. In the last 2 years, have you or a member of your family moved to another area and lived away from home in order to work in any type of agriculture (farm work}? ☐Yes ☐No 3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age (too old to do the work)? ☐Yes ☐No 4. Are you seeking employment in agriculture?☐Yes ☐No			
Are you a Veteran of the US Military? ☐Yes ☐No Family Size: Monthly Gross Income(estimate):			