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Health care that empowers

PATIENT REGISTRATION FORM
(please print)

TODAYS DATE:	INSURANCE CARD COPIED: ❒ Yes ❒ No

PATIENT INFORMATION				
❒ Mr.	❒ Miss	❒ Ms.	❒ Mrs.	GENDER: ❒ M ❒ F

PATIENT'S LAST NAME:	FIRST:	MIDDLE:	PREVIOUS LAST:	NICKNAME:

MEDICARE NO / MEMBER INS ID:	GOVERNMENT ISSUED ID NO.:	BIRTHDATE: / /

CELL/HOME PHONE NO.: ( )	ALT PHONE NO.: ( )	EMAIL ADDRESS:

PRIMARY LANGUAGE SPOKEN:

MARITAL STATUS: ❒ Single ❒ Widow ❒ Separated ❒ Married ❒ Divorced ❒ Domestic Partner

PRIMARY PROVIDER NAME: PHONE NO.:

HOW DID YOU HEAR ABOUT US? ❒ Family/Friend ❒ Internet ❒ Website ❒ Insurance

❒ Physician _____ ❒ Employer /Community event ❒ Brochure/Flyer

❒ Other _____

(REQUIRED BY THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES)			
RACE: ❒ American Indian or Alaskan Native	❒ Asian	❒ Black or African American	❒ White
❒ Native Hawaiian or Pacific Islander	❒ Unknown/Not Reported		
ETHNICITY: ❒ Hispanic or Latino	❒ Not Hispanic or Latino	❒ Unknown/Not Reported	

INSURANCE INFORMATION		
PATIENT COVERED BY INSURANCE: ❒ Yes ❒ No	❒ CASH PATIENT	
NAME OF PRIMARY INSURANCE:		
SUBSCRIBER'S NAME (IF DIFFERENT FROM PATIENT):	MEDICARE NO / MEMBER INS ID (IF DIFFERENT FROM PATIENT):	BIRTH DATE (IF DIFFERENT FROM PATIENT): / /
GROUP NO.:	POLICY NO.:	CO-PAYMENT: $
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❒ Self ❒ Spouse ❒ Child ❒ Other		

NAME OF SECONDARY INSURANCE (IF APPLICABLE):		
SUBSCRIBER'S NAME (IF DIFFERENT FROM PATIENT):	BIRTH DATE (IF DIFFERENT FROM PATIENT): / /	
GROUP NO.:	POLICY NO.:	CO-PAYMENT: $
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❒ Self ❒ Spouse ❒ Child ❒ Other		

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PATIENT REGISTRATION FORM
(Continued)

EMERGENCY CONTACT	
CONTACT NO. 1 FULL NAME:	RELATIONSHIP TO PATIENT:
HOME / CELL PHONE NO.: ( )	ALTERNATE PHONE NO.: ( )
CONTACT NO. 2 FULL NAME:	RELATIONSHIP TO PATIENT:
HOME / CELL PHONE NO.: ( )	ALTERNATE PHONE NO.: ( )