LA RED HEALTH CENTER
REGISTRATION FORM

PATIENT INFORMATION

Name(First, MI, Last): _____

Social Security #: _____-____-_____

Address: _____

P.O. Box: _____

City:_____

State:_____ Zip-Code:_____

Home Phone #: (_____) _____-_____

Work Phone #: (_____) _____-_____

Cell Phone #: (_____) _____-_____

Can We Leave You A Voice Mail Message? Yes [ ] No [ ]

Marital Status: Single [ ] Married [ ] Divorced [ ]
Widowed [ ] separated [ ]

Sex: M [ ] F [ ] Date of Birth: _____/_____/_____ MM/DD/YY

Referring Physician:_____

Are You Enrolled in CHAP? Yes [ ] No [ ]

Primary Language: _____

Race: Black/Afr. Amer. [ ] White [ ] Native Hawaiian [ ]
Asian [ ] Amer. Indian/Alaska Native [ ]
Other Pacific Islander [ ] More than 1 [ ]

Ethnic Group: Hispanic/Latino [ ] Other [ ] _____

Country of Birth: _____

Emergency Contact: _____

Emergency Contact Phone #: (_____) _____-_____

Contact Relationship: _____

Can We Leave A Voice Mail Message With Them? Yes [ ] No [ ]

Are You A Veteran? Yes [ ] No [ ]

Housing Status? Own/Rent [ ] Homeless Shelter [ ]
Transitional [ ] Doubling Up [ ] Street [ ] Other [ ]

How did you hear about La Red Health Center? Work [ ] Radio [ ] Public Health [ ] Brochure [ ] Other [ ]_____

EMPLOYER INFORMATION

Student [ ] Employed [ ] Self Employed [ ] Unemployed [ ] Retired [ ]

Employer: _____

Employer Phone Number: (_____) _____-_____

Employer Address: _____

City:_____ State:_____ Zip-Code:_____

E-Mail Address:_____

INSURANCE INFORMATION

Primary Insurance: _____

Effective Date: _____/_____/_____ MM/DD/YY

Subscriber Name: _____

Certificate #: _____

Group Name: _____

Group #: _____

Policy Telephone #: (_____) _____-_____

Patient's Relationship: Self [ ] Spouse [ ] Child [ ] Other [ ]

Subscriber's DOB_____/_____/_____ SSN#:_____-____-_____

Secondary Insurance: _____

Effective Date: _____/_____/_____ MM/DD/YY

Subscriber Name: _____

Certificate #: _____

Group Name: _____

Group #: _____

Policy Telephone #: (_____) _____-_____

Patient's Relationship: Self [ ] Spouse [ ] Child [ ] Other [ ]

Subscriber's DOB_____/_____/_____ SSN#:_____-____-_____

If patient is under 18 years of age, please fill out: PARENT/ LEGAL GUARDIAN INFORMATION

Name(First, MI, Last): _____

Address : _____

P.O. Box: _____

City:_____ State:_____ Zip-Code:_____

Social Security #:_____-____-_____

Sex: M [ ] F [ ] Date of Birth: _____/_____/_____ MM/DD/YY

Home Phone #: (_____) _____-_____

Work Phone #: (_____) _____-_____

Cell Phone #: (_____) _____-_____

Relationship to Child: _____

I certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at the time of service unless other arrangements have been made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health insurance carrier or payer of my health benefits may pay less than the actual bill for services, and I am ultimately responsible for any balances. I authorize my provider to release any information necessary for my course of treatment or requested by my insurance carrier. I have been offered and/or received a copy of the HIPAA polices of La Red Health Center.

_____ _____ _____/_____/_____

Patient's (Guardian if patient is under 18) Signature Print Date

Revised 03-2010