

SOUTHWEST COMMUNITY HEALTH CENTER

&

CHANATE FAMILY PRACTICE ELSIE ALLEN ROSELAND CHILDREN'S

Registration Form

Patient Information

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ City: _____, CA Zip Code: _____

Phone (home): _____ (cell/msg) _____ (work) _____

Date of birth: ____/____/____ Sex: Male/Female/Other Social Security #: ____-____-____

Marital Status: Single Married Divorced Widowed Separated Partner Other

Employment Type: If agriculture, Employed year round _____ Migrant _____ Seasonal _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Responsible Party Information (if patient under 18 year's old, fill in parent/legal guardian information below)

Last Name: _____ First name: _____ MI: _____

Date of Birth ____/____/____ Social Security #: ____-____-____

Phone/Cell: _____ Sex: Male/Female/Other

Mailing Address: _____ City: _____, CA Zip Code: _____

Relationship to Patient: Mother Father: Other: _____

Payment Source from Insurance Card

Insurance Co. Name _____ Subscriber ID _____

Insured Subscriber Name _____ Relationship _____

DOB _____

Self-Pay

Benefits: General/Public Assistance Retirement None
Other: _____

Monthly household gross income: (approximate) \$ _____ Patient's household size: _____

I give permission to the Health Center to review pharmacy records that relate to the health care I receive.

_____ (initials)

Pharmacy Name: _____ Location: _____

Medicare Medication Insurance: _____

Additional Patient Information (please answer all questions)

By answering the following questions, you will us information we need to acquire grants funds to help uninsured and underinsured people in our community. This information also helps us recognize clients who may qualify for specially funded programs or services. Southwest and Chanate Family Practice is a non-profit organization. Please help us serve our community to the best of our abilities by providing us with this information. This information will become a part of your confidential medical record.

May (permission) we contact you by phone? Yes _____ No _____

If no, how may we contact you? _____

Race: African-American American-Indian Asian Pacific Islander White
More than One Unknown Other: _____

Ethnicity: Hispanic/Latino: Yes _____ No _____

Language: What is the patient's primary language? _____ Do they require translation? Yes _____
No _____

Housing Type/characteristic: Has patient been homeless at anytime since January of this year? Yes _____ No _____
If yes, Homeless shelter _____ Doubling Up _____ On street _____

Veteran status: Yes _____ No _____

The foregoing information is true to the best of my knowledge. I give my consent for the employees at SCHC to do all necessary examinations, diagnostic procedures, and treatments deemed necessary in delivering health care to me. I acknowledge my responsibility to pay for services according to the policies of SCHC. I further understand that I am responsible for any services rendered by SCHC that are considered a NON-COVERED service by my insurance company, and that I am obligated to understand the guidelines and/or restrictions of my insurance. I authorize the release of any medical or other information necessary to process medical claims. I request payment of government benefits to SCHC for care they render. I authorize payment of medical benefits from my insurance to SCHC.

Signature (legal guardian if patient is minor) _____

Date: _____