



LA RED HEALTH CENTER REGISTRATION FORM

PATIENT INFORMATION

Name(First, MI, Last): _____ Social Security #: _____ - _____ - _____ Address: _____ P.O. Box: _____ City: _____ State: _____ Zip-Code: _____	Are You Enrolled in CHAP? Yes <input type="checkbox"/> No <input type="checkbox"/> Primary Language: _____ Race: Black/Afr. Amer. <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More than 1 <input type="checkbox"/> Ethnic Group: Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/> _____ Country of Birth: _____
Home Phone #: (____) _____ - _____ Work Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____ Can We Leave You A Voice Mail Message? Yes <input type="checkbox"/> No <input type="checkbox"/> Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> separated <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/> Date of Birth: ____/____/____ MM/DD/YY Referring Physician: _____	Emergency Contact: _____ Emergency Contact Phone #: (____) _____ - _____ Contact Relationship: _____ Can We Leave A Voice Mail Message With Them? Yes <input type="checkbox"/> No <input type="checkbox"/> Are You A Veteran? Yes <input type="checkbox"/> No <input type="checkbox"/> Housing Status? Own/Rent <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Other <input type="checkbox"/>
How did you hear about La Red Health Center? Work <input type="checkbox"/> Radio <input type="checkbox"/> Public Health <input type="checkbox"/> Brochure <input type="checkbox"/> Other <input type="checkbox"/> _____	

EMPLOYER INFORMATION

Student <input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Employer: _____ Employer Phone Number: (____) _____ - _____	Employer Address: _____ City: _____ State: _____ Zip-Code: _____ E-Mail Address: _____
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INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: ____/____/____ MM/DD/YY Subscriber Name: _____ Certificate #: _____ Group Name: _____ Group #: _____ Policy Telephone #: (____) _____ - _____ Patient's Relationship: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Subscriber's DOB ____/____/____ SSN#: _____ - _____ - _____	Secondary Insurance: _____ Effective Date: ____/____/____ MM/DD/YY Subscriber Name: _____ Certificate #: _____ Group Name: _____ Group #: _____ Policy Telephone #: (____) _____ - _____ Patient's Relationship: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Subscriber's DOB ____/____/____ SSN#: _____ - _____ - _____
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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 <input type="checkbox"/> F <input type="checkbox"/> Date of Birth: ____/____/____ MM/DD/YY Home Phone #: (____) _____ - _____ Work Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____ Relationship to Child: _____
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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