PATIENT REGISTRATION FORM-INFORMACION GENERAL DEL PACIENTE

Last Name-Apellido: _____

First Name-Nombre: _____

Mailing Address-Direccion de Correo: _____ _

_____

Physical Address-Direccion Fisica: _____

City-Ciudad: _____ State-Estado:_____

Zip Code-Codigo Postal_____Sex-Sexo (M/F):_____

Telephone #-Numero de Telefono: _____

Work Phone-Numero de Trabajo: _____

Date of Birth-Fecha de Nacimiento:_____/_____/_____

Soc.Security #--Numero de Seguro Social:_____

Marital Status-Estado Civil: ☐ Single-Soltera/o
☐Married-Casada/o ☐ Other-Otro

Ethnicity-Etnico: ☐Hispanic- Hispano ☐ Non-Hispanic-No Hispano

Race-Origen: ☐ White/Caucasian-Blanco/Del Caucaso
☐Asian- Asia
☐ African American-Africano Americano
☐ Pacific Islander-Isleño Pacifico
☐ Native Americans/ Nativos de Alaska
☐ Unknown-Raza Desconocido
☐ Multiple Races-Multiples Razas

Veteran-Veterano: ☐ Yes-Si ☐ No

☐ Interpretation Services-Servicios de Interpretacion

☐Employed-Empleado ☐Unemployed-Desempleado
☐Student-Estudiante
☐Infant- Child-Bebe/Nino
☐Retired-Retirado ☐Disabled-Discapacitado

Employer Address- _____

Direccion de Empleado-_____

HEAD OF HOUSEHOLD INFORMATION-INFORMACION DE PERSONA RESPONSABLE DE DOMICILIO

Responsible Party-Persona Responsable:_____ Relationship-Relacion:_____

Address-Direccion:_____ Phone#-Telefono:_____

Physical Adress-Direccion Fisica:_____ City-Ciudad_____State-Estado_____
Zip Code-CodigoPostal_____

EMERGENCY CONTACT-EN CASO DE EMERGENCIA

Name-Nombre-_____Relation-Relacion:_____ Phone #-Telefono#_____

INSURANCE INFORMATION-INFORMACION DE ASEGURANZA

Name of Insurance-Compania de Aseguranza:_____ Policy #-Numero de Grupo_____

Policy Holder-Nombre del Supsciptor:_____ Soc. Sec. #-Numero deSeguro Social_____

Relationship-Relacion con el Paciente:_____ Date of Birth-Fecha de Nacimiento:_____/_____/____
Sex-Sexo: ☐M ☐F
Policy Holder Address-Direccion del Supsciptor:_____Ciudad:_____Estado_____

Zip Code-Codigo Postal_____
Policy Holder Phone-Supsriptor Numero de Telefono:_____ Empleado Por:_____

Plan Rx Medicare-Numero de Plan Rx _____Telephone-Numero de Telefono_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND I MUST REPORT IMMEDIATELY ANY CHANGES IN MY INSURANCESTATUS OR INCOME. I HEREBY GIVE AUTHORIZATION TO RELEASE ANY INFORMATION FOR AUDITING PURPOSES AND TO DETERMINE ELIGIIBILITY. IF ANY INFORMATION IS FALSIFIED, I WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED.

YO CERTIFICO QUE ESTA INFORMACION ARIBA ES CORRECTA Y DEBO REPORTAR CAMBIOS IMEDIATAMENTE SOBRE MIS INGRESOS Y/O ASEGURANZA. YO DOY PERMISO PARA CUALQIER INFORMACION NECESARIA PARA REVISAR OBJETIVOS Y DETERMINAR ELIGIBILIDAD. SI ALGUNA INFORMACION ES FALSA, YO SERE RESPONSABLE PARA OBTENER EL PAGO DE LOS SERVICIOS PROVEEDOS.

_____	_____	_____	_____
Patient Signature-Firma del Paciente	Date-Fecha	Staff initials-Iniciales del Personal	Date-Fecha

Chart #-Expediente _____ Main chart-#- Expediente Primario_____

STAFF USE ONLY – PARA USO DE PERSONAL

In the last 2 years (or prior to retirement) have you or the family member upon whom you are dependent:

1. Done agricultural related farm work (year round or on a seasonal basis)?
   ☐Yes ☐ No
2. Derived more than 50% of your working income or employment from agricultural related Farm work?
   ☐ Yes ☐No
3. Moved or traveled to establish a temporary residence in order to do agriculture related Farm work?
   ☐ Yes ☐ No

☐ Migrant ☐ Seasonal ☐ Other

☐ Medicare ☐ Medicaid ☐ CHIP ☐ Private Insurance ☐ Indigent ☐ Other

FINANCIAL INFORMATION

DATE				
TOTAL INCOME				
# OF DEPENDENTS				
CLASS CODE				
EXPIRATION DATE				
STAFF INITIALS				
PATIENT SIGNATURE*				

* If applying for the Astra Zeneca Prescription Program my signature certifies that I do not have any prescription coverage.

COMMUNITY HEALTH DEVELOPMENT, INC.
HOUSEHOLD INFORMATION FORM

Head of Household:______________________________ **Soc. Sec. #:______-______-______**

Mailing Address:________________________________ **Date of Birth:______-______-______**

Physical Address:________________________________ **Marital Status: □ Single□ Married □ Other**

City:_____________________ State________________ **Sex: □ Male □ Female**

Zip: _________________ Phone #:____________________

Employer:____ **Work Address:______________________________**

City:_________________________ State:_____________ **Zip:_______________ Phone #:_____________**

Spouse:____ **Soc. Sec. #: ______-______-______**

Employer:_______________________________________ **Date of Birth: ______/______/______**

Work Address: _________________________________ **Sex: □ Male □ Female**

City:________________________ State:________________ ***Zip: _____________Phone#:*** **_________________**

HOUSEHOLD MEMBERS	DATE OF BIRTH	SEX	SOC. SEC. #	RELATION	CHART #
______________________	_____/_____/_____	□ Male □ Female	______-______-______	___________	_______
______________________	_____/_____/_____	□ Male □ Female	______-______-______	___________	_______
______________________	_____/_____/_____	□ Male □ Female	______-______-______	___________	_______
______________________	_____/_____/_____	□ Male □ Female	______-______-______	___________	_______
______________________	_____/_____/_____	□ Male □ Female	______-______-______	___________	_______
______________________	_____/_____/_____	□ Male □ Female	______-______-______	___________	_______
______________________	_____/_____/_____	□ Male □ Female	______-______-______	___________	_______

CHART #_________________