

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

REASON FOR TODAY'S VISIT:  
\_\_\_\_\_

## PATIENT REGISTRATION FORM

**\*\*PLEASE PRINT CLEARLY\*\***

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

SSN#: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

SEX: MALE FEMALE  
(Circle One)

MARITAL STATUS: M S W D  
(Circle One)

PERMANENT ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TEMPORARY ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATES THERE: FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PATIENT EMPLOYED: \_\_\_\_\_ RETIRED: \_\_\_\_\_ STUDENT: \_\_\_\_\_

IF EMPLOYED: EMPLOYER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

PHONE#: \_\_\_\_\_ EXT: \_\_\_\_\_

**IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:**

GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

GUARDIAN SSN#: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

## INSURANCE INFORMATION

### PRIMARY INSURANCE

INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IDENTIFICATION #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

PRIMARY INSURED NAME:

LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

SSN#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

RELATIONSHIP TO INSURED (Circle One): SELF SPOUSE CHILD EMPLOYER

ADDRESS (IF OTHER THAN YOUR OWN): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ PHONE#: \_\_\_\_\_

IS THIS YOUR EMPLOYER HEALTH PLAN?: YES NO

IF YES: PRIMARY INSURED EMPLOYER \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### SECONDARY INSURANCE

INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IDENTIFICATION #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

PRIMARY INSURED NAME:

LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

SSN#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

RELATIONSHIP TO INSURED (Circle One): SELF SPOUSE CHILD EMPLOYER

ADDRESS (IF OTHER THAN YOUR OWN): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE#: \_\_\_\_\_

IS THIS YOUR EMPLOYER HEALTH PLAN?:        YES                NO

IF YES: SECONDARY INSURED EMPLOYER \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PLEASE PRESENT YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE FOR COPYING.  
IF YOU DON'T HAVE YOUR INSURANCE CARDS, PAYMENT IS EXPECTED WHEN  
SERVICES ARE RENDERED.**

**PLEASE CAREFULLY READ THE FOLLOWING INFORMATION**

**I UNDERSTAND THIS IS A LIFETIME AUTHORIZATION**

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:**

I authorize treatment of the patient named herein, and agree to pay all fees for me and my family shown by statements promptly upon presentation thereof unless advance credit arrangements are agreed upon in writing. Charges on statements are agreed to be correct and reasonable unless protested in writing within thirty days of the billing date.

It is agreed that payments will not be delayed or held due to insurance coverage, and all proceeds of insurance benefits have been assigned to Bonita Community Health Center, Inc. Please note a copy of the assignment of benefits is as valid as the original.

PRINT PATIENT NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE OF GUARDIAN: \_\_\_\_\_

**INSURANCE & MEDICAL RECORD RELEASE AUTHORIZATION:**

I authorize and consent to the release of any and all medical information needed for treatment by Bonita Community Health Center, Inc.

I authorize and consent to release any medical information about the patient named herein, for this or a related claim to my insurance company.

I authorize and consent to the release of any and all medical information to your insurance company to authorize and/or pre-certify you for medically necessary procedures and/or tests.

PRINT PATIENT NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE OF GUARDIAN: \_\_\_\_\_

**IF YOUR VISIT IS WORK RELATED PLEASE COMPLETE THE FOLLOWING:**

EMPLOYER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CASE MANAGER: \_\_\_\_\_ PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_

**IF WORK RELATED YOU MUST HAVE CONTACTED YOUR EMPLOYER.  
WE MUST HAVE A WORKERS' COMP CLAIM NUMBER AND  
AUTHORIZATION TO SEE YOU BEFORE YOUR VISIT.**

**IF YOUR VISIT IS MOTOR VEHICLE RELATED PLEASE COMPLETE THE FOLLOWING:**

INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IDENTIFICATION #: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_/\_\_\_\_/\_\_\_\_

CLAIM #: \_\_\_\_\_

ADJUSTER: \_\_\_\_\_ PHONE #: \_\_\_\_\_