



HEALTH CENTER

REGISTRATION FORM

MR# _____

Patient _____
(LAST) (FIRST) (M.I.)

SS# ____/____/____ D.O.B. _____ Male ___ Female ___ (mark one)

MAILING address _____
(Street) (Town) (State) (Zip)

RESIDENTIAL address (If different from above)

(Street) (Town) (State) (Zip)

Home Phone# _____ Work or Cell# _____
(please indicate)

Language Spoken: _____ Need Translator: Y/N Ethnicity: _____ Origin: _____

Marital Status _____ If married, spouse's name _____

If child is under 18: _____
(mother's name) (father's name)

Child lives with: Mother ___ Father ___ Both ___

Where did you hear about us? _____

EMERGENCY CONTACT: _____ Relationship: _____
Telephone# _____

Health Insurance? _____
(please provide reception with your card to copy)

I hereby authorize the staff of the CHP Health Center to render such medical services as may be deemed necessary to me. I also authorize the release of all necessary medical information to insurance companies, third party payers, utilization review and regulatory agencies, medical providers and companies or community resources that will/may assist me to meet my health care needs.

I have read and understand my rights and responsibilities as a patient of the CHP Health Center. I assign CHP Health Center authority to claim and collect medical insurance benefits and payments on my behalf.

SIGNATURE: _____ Date: _____
In case of a minor child: Parent Legal Guardian Emancipated Minor