

PATIENT REGISTRATION FORM-INFORMACION GENERAL DEL PACIENTE

Last Name-Apellido: _____ Telephone #-Numero de Telefono: _____
First Name-Nombre: _____ Work Phone-Numero de Trabajo: _____
Mailing Address-Direccion de Correo: _____ Date of Birth-Fecha de Nacimiento: ____/____/____

Soc.Security #-Numero de Seguro Social: _____
Physical Address-Direccion Fisica: _____ Marital Status-Estado Civil: ☐ Single-Soltera/o
☐ Married-Casada/o ☐ Other-Otro
City-Ciudad: _____ State-Estado: _____
Zip Code-Codigo Postal _____ Sex-Sexo (M/F): _____ Ethnicity-Etnico: ☐ Hispanic- Hispano ☐ Non-Hispanic-
No Hispano
Race-Origin: ☐ White/Caucasian-Blanco/Del Caucazo
☐ Asian- Asia ☐ African American-Africano Americano
☐ Pacific Islander-Isleño Pacifico ☐ Native Americans/ Nativos de Alaska
☐ Unknown-Raza Desconocido ☐ Multiple Races-Multiples Razas
☐ Student-Estudiente

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

EMERGENCY CONTACT-EN CASO DE EMERGENCIA

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

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND I MUST REPORT IMMEDIATELY ANY CHANGES IN MY INSURANCE STATUS OR INCOME. I HEREBY GIVE AUTHORIZATION TO RELEASE ANY INFORMATION FOR AUDITING PURPOSES AND TO DETERMINE ELIGIBILITY. 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 CUALQUIER 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 _____