CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Registration Form

Patient Information

Last Name:	First Name:	Middle:	Nickname:
Social Security Number: - -		Date of Birth: / /	

Sexual Orientation

Birth Sex:
☐ Male ☐ Female
☐ Undifferentiated ☐ Unknown

Current Gender:
☐ Male ☐ Female
☐ Undifferentiated

Gender Identity:
☐ Male
☐ Male to Female (MTF)/Trans Female/Trans Woman
☐ Choose not to disclose
☐ Additional gender category or other, please specify: _____
☐ Female
☐ Female to Male (FTM)/Trans Male/Trans Man
☐ Genderqueer, neither exclusively Male nor Female

Sexual Orientation:
☐ None
☐ Bisexual
☐ Choose not to disclose
☐ Don't know
☐ Lesbian, Gay, Homosexual
☐ Straight or Heterosexual

Preferred Pronoun:
☐ Asked but unknown
☐ Decline to Answer
☐ He, Him, His
☐ Other: _____
☐ She, Her, Hers
☐ They, Them, Theirs
☐ Ze, Hir

Demographics

Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:

Marital Status: ☐Single ☐Married ☐Divorced ☐Legally Separated ☐Widowed ☐Interlocutory ☐Domestic Partner ☐Life Partner

Preferred Language: ☐ English ☐ Spanish ☐ Mixteco ☐ Other:_____	Home Phone: ( ) -	Cell Phone: ( ) -	Email Address:

Primary Care Provider:

Insurance Information (Please present your insurance card)

Type(s) of Health Care Coverage: Private Insurance Medi-Cal Medicare None Other: _____

Primary:	ID #:	Group #:
Secondary:	ID #:	Group #:

Is your visit due to a(n): Auto Accident? Yes No Job Related injury? Yes No

Person Responsible (*Must be an adult over 18 years old)*

Last:	First Name:	Middle:	
Date of Birth: / /	Social Security Number: - -	Relation to Patient:	
Home Address:	City:	State:	Zip:

Homeless Status (Please answer the following questions in order for us to better serve you.)

1. Are you currently living with friends or family, in your car, in a shelter, in a hotel or on the street? ☐Yes ☐No
2. Are you living in Public Housing ☐Yes ☐No

Agricultural Status (Please answer the following questions in order for us to better serve you.)

1. In the last 2 yrs., have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, worked with animals like cows, chickens, etc. ☐Yes ☐No

2. In the last 2 yrs., have you or anyone in your family established a temporary home in order to work in any type of agriculture (farm work)? ☐Yes ☐No

3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age (too old to do the work)? ☐Yes ☐No

Patient Registration Form

Race/Ethnicity

Race (Mark all that are applicable):

- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ More than one race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Unreported/Refused to Report
- ☐ White

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown/ Not Reported

Veteran Status

1. Are you a U.S. Veteran? ☐Yes ☐No

Family Income *(For Reporting Purposes Only)*

Family Size: __0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

Estimated Annual Household Income: $_____

Pharmacy Information

Primary Pharmacy

Pharmacy Name: _____

Address: _____

City:_____ State: _____ Zip Code:_____

Phone Number:_____

Fax Number: _____

Secondary Pharmacy (if applicable):

Pharmacy Name: _____

Address: _____

City:_____ State: _____ Zip Code:_____

Phone Number:_____

Fax Number: _____

Emergency Contact

Emergency Contact Name:_____

Relationship to Patient:_____

Phone Number (different from primary contact number(s) stated on reverse): ( ) -

How Did You Hear About Us?

Please mark one of the following

- ☐ Friend/Family Member
- ☐ Website/ Internet
- ☐ Newspaper
- ☐ Yellow Pages
- ☐ Radio
- ☐ Mailed Advertisement
- ☐ Insurance Referral
- ☐ Physician Referral (list name):_____
- ☐ Other (please specify):_____

I hereby consent to any necessary medical or surgical treatment, which may include prescribed medications issued by the provider. I understand that even simple treatments or diagnostic measures have a risk of complications. In such cases, further consultation with the provider may be necessary. Clinicas Del Camino Real, Inc. will make referrals for specialized services we are unable to provide here.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I understand that I am financially responsible for all charges, whether covered or paid by said insurance. Should Clinicas Del Camino Real, Inc. participate with my insurance plan all co-payments and co-insurance payments are due at the time services are rendered. I hereby assign to Clinicas Del Camino Real, Inc. all insurance benefits to which I am (or my child is) entitled, including but not limited to Medicare, Private Health Insurance, and any other form of coverage paying benefits. I hereby authorize Clinicas Del Camino Real, Inc. to release all necessary information to secure payment.

Date:_____ Name (Print):_____ Signature:_____