

**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: \_\_\_\_\_

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

Zip Code-Codigo Postal \_\_\_\_\_ Sex-Sexo (M/F): \_\_\_\_\_

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 de Seguro 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-Supsciptor 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 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 \_\_\_\_\_

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**

<b>DATE</b>				
<b>TOTAL INCOME</b>				
<b># OF DEPENDENTS</b>				
<b>CLASS CODE</b>				
<b>EXPIRATION DATE</b>				
<b>STAFF INITIALS</b>				
<b>PATIENT SIGNATURE*</b>				

\* 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 #
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\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  Male  Female \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  Male  Female \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  Male  Female \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  Male  Female \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  Male  Female \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  Male  Female \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  Male  Female \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_

CHART # \_\_\_\_\_