Patient Registration	Today's date:
Please fill out completely. The information collected here correlates to the funding we receive as a not-for-profit health care center. We have to update patient information annually.	
Last Name: First: Middle:	
Nickname:	**Date of Birth**:
Social Security:	Birth Sex: ☐Male ☐Female ☐Decline to Specify
Billing Address: City: State: Zip:	
Physical Address: City: State: Zip:	
Home Phone #:	Cell Phone #:
Work Phone #:	If you cannot be reached, is it okay to (please select all that apply): ☐Leave Message on Machine ☐Leave Message with Person ☐Text
Email (for event purposes only):	
Marital Status: ☐Married ☐Single ☐Domestic Partner ☐Separated ☐Divorced ☐Widow(er) ☐Decline to Specify	
Are you a Student: ☐No ☐Yes: ☐Full Time ☐Part Time	Preferred Language:
Primary Care Provider: ☐Thomas Bertolli, MD ☐Mark Kal, MD ☐Clement Binnnings, MD ☐Afsoon Foorohar, DO ☐Jesse Ewing, PA ☐Lois Falk, FNP ☐Undecided ☐Not RCMS (Specify):	
Emergency Contact: Name: Date of Birth: Their Phone #: Relation to patient:	
If you would like RCMS to share any information about your care/appointments with anyone, please ask for (a) "Support Role" form(s). Your information will otherwise remain private.	
Homeless: ☐No ☐Yes: ☐Doubling Up ☐Shelter ☐Street Campground ☐Transitional Housing	
Migrant Worker: ☐Yes ☐No / Need for Interpreter: ☐Yes ☐No	Veteran: ☐Yes ☐No
Race: ☐Native American/Alaskan ☐Asian ☐Black/African American ☐Hispanic/Latino ☐Multi-Racial ☐Native Hawaiian ☐ Other Pacific Islander ☐White	Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino
Gender Identity: ☐Female ☐Transgender to Male ☐Genderqueer/Non-Binary ☐Male ☐Transgender to Female ☐Additional Category ☐Decline to Specify	Sexual Orientation: ☐Heterosexual ☐ Homosexual ☐Bisexual ☐Additional Category ☐Decline to Specify
Family Size:	Gross Annual Income: ☐$0-$15,999 ☐$16,000-$21,999 ☐$22,000 - $30,999 ☐$31,000+
Insurance: ☐Medicare ☐MediCal ☐Family Pact ☐None ☐ Private Insurance /Other:	

CONTINUE ON BACK ➡

Person Responsible for Payment (if not self): Name: Date of Birth:

Relationship: Mailing Address:

CONSENT TO TREATMENT: The undersigned consent to the medical/dental examination, immunizations, diagnostic procedures, treatment and procedures for the care of the above named Patient, which the physician/physician assistant/nurse practitioner/dentist consider necessary or advisable.

MEDICARE ASSIGNMENT: I certify that the information given by me in applying or payment under Title VII of the Social Security Act is correct. I request that payment of authorized benefits be made in my behalf.

ASSIGNMENT OF INSURANCE BENEFITS: In the event I am entitled to benefits arising out of any policy of insurance insuring or any party liable to me, I hereby assign said benefits directly to Redwood Coast Medical Services, Inc., for application to my bill. I agree that Redwood Coast Medical Services, Inc. may issue a receipt for any such payment, that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for charges not covered by the agreement.

Acknowledgement of Receipt of Privacy Practices

By law, we are required to provide you with our Notice of Privacy Practices. This notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Redwood Coast Medical Services' health care operations. This notice also describes my rights with respect to my medical/protected health information. Please review carefully.

As a patient, you have the following rights that include but are not limited to:

1. The right to inspect and copy your information,
2. The right to request correction to your information,
3. The right to request that your information be restricted,
4. The right to confidential communication,
5. The right to a report of disclosure of your information, and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private. Redwood Coast Medical Services reserves the right to change the practices that are described in the Notice of Privacy Practices.

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact: RCMS' Chief Executive Officer
PO Box 1100
Gualala, CA 95445
707-884-4005

I acknowledge that I was provided with a copy of the RCMS Notice of Privacy Practices:

Name of Patient:	DOB:
Signature:	Date:
If Signed by Representative: Name:	Relationship:

For RCMS Use Only: I have made a good faith effort to obtain a written acknowledgement of receipt of RCMS Notice of Privacy Practices but was unable to for the following reason: ☐Patient Refused to Sign ☐Patient Unable to Sign

Employee Name: Date: