RCMS COMMUNITY HEALTHCARE

PATIENT REGISTRATION FOR A MINOR

Today's Date: _____

Patient Name: Last_____First_____Middle_____

Nickname: _____

Social Security #: ____ - ____ - _____ **Date of Birth: _____/_____/_____** **Gender: ☐ Male ☐ Female**

Mailing/Billing Address: _____ City_____State:_____Zip_____

Street Address: _____City_____State:_____Zip_____

CONTACT INFORMATION – Home or Cell Phone Number Required

PATIENT:

☐ Home Phone _____ ☐ Cell Phone _____

☐ OK to leave message with person who answers the phone ☐ OK to send a text message

☐ OK to leave message on answering machine ☐ NOT OK to leave a message

☐ DO NOT CALL UNDER ANY CIRCUMSTANCES (If checked) Alternative Contact Required_____

☐ Work Phone _____

Parent/Guardian Name: _____ Relationship: _____

DOB: _____ ☐ RESPONSIBLE PARTY (including payments) ☐ DO NOT CALL UNDER ANY CIRCUMSTANCES

☐ Home Phone _____ ☐ Cell Phone _____

☐ OK to leave message with person who answers the phone ☐ OK to send a text message

☐ OK to leave message on answering machine ☐ Not OK to leave a message

☐ Work Phone _____

(OPTIONAL) Parent/Guardian Name: _____ Relationship: _____

DOB: _____ ☐ RESPONSIBLE PARTY (including payments) ☐ DO NOT CALL UNDER ANY CIRCUMSTANCES

☐ Home Phone _____ ☐ Cell Phone _____

☐ OK to leave message with person who answers the phone ☐ OK to send a text message

☐ OK to leave message on answering machine ☐ Not OK to leave a message

☐ Work Phone _____

Emergency Contact _____

(Name) (Phone) (Relationship) (DOB)

Primary Care Provider

☐ Thomas Bertolli, MD ☐ Mark Kal, MD ☐ Other: Specify_____

☐ Lois Falk, FNP ☐ Jesse Ewing PA-C

Is the patient a student: ☐Yes □No if yes, □ Full Time □ Part Time

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: ☐Native American/Alaskan Native ☐Asian ☐Hispanic/Latino

☐Native Hawaiian ☐Other Pacific Islander ☐Multi-racial

☐White ☐Black/African American

Primary (Preferred) Language: _____ Need for Interpreter ☐ Yes ☐ No

PAYMENT AND INSURANCE INFORMATION (RESPONSIBLE PARTY) (***Please provide insurance card)***

Subscriber Name: _____ ***Subscriber Date of Birth:*** _____

Relationship to Patient: _____

☐Medi-Cal ☐Medicare ☐Private Insurance ☐Family Pact ☐No Insurance □Medicare Advantage Plan

☐Other **Secondary/Supplemental Insurance:** _____

Family Size: _____ **Gross Annual Income:** ☐ $0-$15,999 ☐ $16,000-$21,999 ☐ $22,000 - $30,999 ☐ $31,000+

Seasonal Worker ☐Yes ☐ No **Employer:** _____

Homeless ☐Yes ☐No

If Yes, current living conditions ☐ Shelter ☐ Street/Campground ☐ Transitional Housing

☐ Doubling Up (family or friend) ☐ Other

CONDITIONS OF TREATMENT

CONSENT TO TREATMENT: The undersigned hereby consent to the administration and performance of all diagnostic procedures and treatment, which, in the judgment of the physician/physician assistant/nurse practitioner/dentist may be considered 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.

➔ **Parent/Guardian Signature**_____ **Date**: _____

May we contact you about Clinic Health Promotions and Special Events? ☐**Yes** ☐**No**

Email Address: _____