



Minor Patient Registration

Please fill it out completely. The information collected correlates to the funding we receive as a not-for-profit health care center. We are required to report patient demographics annually.

Today's date:			
Last Name:		First:	Middle:
Date of Birth:	Preferred First Name:		Preferred Gender Pronoun:
Social Security #:			Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Billing Address:		City:	State: Zip:
Physical Address:		City:	State: Zip:
Parent/Guardian Name:		Date of Birth:	
Relationship:		Cell Phone	
Home Phone:		Work Phone:	
(Optional) Additional Parent/Guardian Name:		Date of Birth:	
Relationship:		Cell Phone:	
Home Phone:		Work Phone:	
Patient Cell Phone (if different):		If you cannot be reached, is it okay to (please select all that apply):	
Email:		<input type="checkbox"/> Leave Message on Machine <input type="checkbox"/> Leave Message with Person <input type="checkbox"/> Text	
Pharmacy:			
Are you a Student: <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			
Preferred Language:		Need for Interpreter: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Current Primary Care Provider: <input type="checkbox"/> Thomas Bertolli, MD <input type="checkbox"/> Lois Falk, FNP <input type="checkbox"/> Afsoon Foorohar, DO <input type="checkbox"/> Holly Hamm, FNP <input type="checkbox"/> Isabell Orellana, PA-C <input type="checkbox"/> Lon Transue, PA-C <input type="checkbox"/> Undecided <input type="checkbox"/> Not RCMS (Specify):			
Emergency Contact Name:		Date of Birth:	
Emergency Contact 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.			
In the past 12 have you: <input type="checkbox"/> worried about running out of food before getting money to buy more <input type="checkbox"/> ran out of food and did not have enough money to buy more <input type="checkbox"/> used a food bank			
Homeless: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doubling Up <input type="checkbox"/> Shelter <input type="checkbox"/> Street Campground <input type="checkbox"/> Transitional Housing			
Race:		Ethnicity:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian		<input type="checkbox"/> Mexican/Mexican American/Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic/Latino/Spanish Origin <input type="checkbox"/> Hispanic/Latino/Spanish Origin Combined <input type="checkbox"/> Not Hispanic/Latino/Spanish Origin <input type="checkbox"/> Choose not to disclose	
<input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian/Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> White <input type="checkbox"/> More than one race <input type="checkbox"/> Choose not to disclose			
Gender Identity:		Sexual Orientation:	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Don't know/Unknown <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Transgender Man/Transgender Male/Transmasculine <input type="checkbox"/> Transgender Woman/Transgender Female/Transfeminine		<input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Don't know/Unknown <input type="checkbox"/> Choose not to disclose	

Family Size:	Gross Annual Income: <input type="checkbox"/> \$0-15,060 <input type="checkbox"/> \$15,061-20,030 <input type="checkbox"/> \$20,031-25,000 <input type="checkbox"/> \$25,001-30,120 <input type="checkbox"/> \$30,121+		
Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare and Medi-Cal <input type="checkbox"/> None/Uninsured <input type="checkbox"/> Private Insurance			
Person Responsible for Payment 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 considers 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.			
Acknowledgment 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:			
<ul style="list-style-type: none"> - The right to inspect and copy your information - The right to request a correction to your information - The right to request that your information be restricted - The right to confidential communication - The right to a report of disclosure of your information - 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 ensure 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 acknowledgment of receipt of RCMS Notice of Privacy Practices but was unable to for the following reason(s): <input type="checkbox"/> Patient Refused to Sign <input type="checkbox"/> Patient Unable to Sign	
Employee Name:	Date: