BARTZ-ALTADONNA
Community Health Center
californiahealth+

BARTZ-ALTADONNA
REGISTRATION FORM
(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	Other names used / Former names?	Mother's Maiden Name	Birth date: / /	Age:	Sex: ❑ M ❑ F ❑ TG	
Transgender Only: What sex were you at birth? ❑ M ❑ F	What gender do you identify with? ❑ M ❑ F	❑ Male to Female ❑ Female to Male ❑ Choose not to disclose				
Street address:	Social Security no.:	Home/Cell: ( ) Ok to leave message: ❑ Yes ❑ No				
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Monthly household income:	How many people in household?					
Sources of Monthly Income: ❑ State Disability Amount:_____ ❑ SSI Amount:_____ ❑ SSDI Amount:_____ ❑ Unemployment Amount:_____ ❑ Food Stamps Amount:_____ ❑ Other Amount:_____						
Are you a student? ❑ Yes ❑ No	Are you a Veteran? ❑ Yes ❑ No	Do you have an Advanced Directive? ❑ Yes ❑ No	Email:			
Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic ❑ Refuse to disclose	What is your preferred language?					
Race: ❑ White ❑ African American ❑ Asian ❑ Pacific Islander ❑ Native Hawaiian ❑ American Indian ❑ Alaska Native ❑ Other (please specify) _____ ❑ Refuse to Disclose						
Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Marketing ❑ Social Media ❑ Outreach Events ❑ Other_____						
Other family members seen here:						
Housing: ❑ Own ❑ Rent (house) ❑ Rent (Apartment) ❑ Living with friend ❑ Living with family ❑ Section 8 ❑ Homeless Please Explain _____ ❑ Seasonal Worker ❑ Migrant Worker						
INSURANCE INFORMATION						
(Please provide your insurance card and Photo ID)						
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )			
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate method of payment: ❑ Medicare ❑ Medi-Cal ❑ HMO ❑ Cash ❑ Other_____						
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						

CONTINUED ON REVERSE

INSURANCE INFORMATION (CONTINUED)

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

The above information is true to the best of my knowledge. I authorize my insurance to pay for services billed by my provider. I understand that I am financially responsible for any balance not covered by my health plan. I also authorize Bartz-Altadonna or insurance company to release any information required to process my claims.

_____
Patient/Guardian Initials

IN CASE OF EMERGENCY

Name of local relative or friend:	Relationship to patient:	Home/Cell: ( )	Work/Other.: ( )
May we disclose medical information to this person? ❑ Yes ❑ No			

List any other individual authorized to accompany patient:

(Proxy/Consent Letter signed by patient/guardian required for each named individual)

Name	Relationship to Patient/Contact Number	HIPAA
		❑ Yes ❑ No
		❑ Yes ❑ No

I <u>acknowledge</u> that the following forms below have been offered and/or received:

❑ **Pediatric Forms**
- Consent to Treat Minors 0-17 years
- Notice of Privacy Practices for PHI
- Patients' Rights and Responsibilities
- Staying Healthy Assessment

❑ **Adult Forms**
- Advance Beneficiary Notice ABN (Medicare Only)
- Advance Directive Form
- Ace Score
- Consent for Medical Surgical/Procedures
- Notice of Privacy Practices for PHI
- Patients' Rights and Responsibilities
- Staying Healthy Assessment

_____	_____	_____
Print Name of Patient/Guardian	*Signature of Patient/Guardian*	*Date*

_____	_____	_____
Bartz-Altadonna Representative (Print)	*Signature of Representative*	*Date*

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

Patient Name (Please Print) _____

I consent to the procedures and treatment that may be performed as a patient of Bartz-Altadonna Community Health Center, including emergency treatment or services, such as laboratory procedures, x-ray examinations, local anesthesia, psychosocial counseling, immunizations, or other services deemed necessary by Bartz-Altadonna Medical Providers. This consent for treatment and/or procedures to be performed shall stay in effect until I or my legal representative cancels such permission. Cancellation may be verbal and/or in writing to Bartz-Altadonna employee during business hours.

Signature _____ Date _____

Witness _____ Date _____

If signed by other than patient, indicate name and relationship to the patient:

Name and relationship with patient _____ Date _____

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