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 Treat Minors

I (we) the parent(s) or legal guardian of _____do hereby authorize treatment of said patient by licensed medical personnel in case of any accident or illness that may arise, or any hospitalization necessary, 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.

The following information might be needed in case of medical emergency please complete and return.

Patient Name: _____
Birth date: _____
Date of Last Tetanus shot: _____

Does the participant have any medical conditions?

Asthma	Diabetes	Allergies	Insect bite reactions	Hay Fever	Other_____
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

If yes explain answers including medications taken.

_____

_____

Is there any medication that should **NOT** be given?

_____

_____

Emergency Contact Name: _____Relationship_____

Phone Number: _____ HIPAA ☐Yes ☐No

_____ Legal Guardian Name (print)	_____ Relationship (print)
_____ Legal Guardian Signature	_____ Date
_____ Witness Print Name (BACHC staff)	_____ Date
_____ Witness Signature (BACHC staff)	

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