



Desert Senita Community Health Center

Patient Registration Form

PATIENT INFORMATION

NAME LAST		FIRST		SOCIAL SECURITY NO.	
STREET ADDRESS		CITY	STATE	ZIP	COUNTY
MAILING ADDRESS/P.O. BOX		CITY	STATE	ZIP	COUNTY
HOME PHONE ()	WORK PHONE ()	BIRTHDATE		SEX: FEMALE _____ MALE _____	
RELATIONSHIP TO RESPONSIBLE PARTY: SELF SPOUSE CHILD OTHER _____			MARITAL STATUS: Single Married Divorced		
RACE (CIRCLE ONE): ASIAN/PACIFIC ISLANDER		BLACK	HISPANIC		PRIMARY LANGUAGE
NATIVE AMERICAN		WHITE	OTHER		
EMERGENCY CONTACT		PHONE ()			

RESPONSIBLE PARTY INFORMATION (Enter name of financially responsible person)

NAME LAST		FIRST			
STREET ADDRESS		CITY	STATE	ZIP	COUNTY
MAILING ADDRESS/P.O. BOX		CITY	STATE	ZIP	COUNTY
HOME PHONE ()	WORK PHONE ()	ANNUAL INCOME		FAMILY SIZE	
EMPLOYER NAME		EMPLOYER ADDRESS			
SOCIAL SECURITY NO.	BIRTHDATE	SEX FEMALE _____ MALE _____		MARITAL STATUS: Single Married Divorced	

INSURANCE COMPANY

PRIMARY INSURANCE	ID#	GROUP#	INSURANCE COMPANY ADDRESS		
NAME OF INSURED	INSURED'S EMPLOYER	RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____			
SECONDARY INSURANCE	ID#	GROUP#	INSURANCE COMPANY ADDRESS		
NAME OF INSURED	INSURED'S EMPLOYER	RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____			
FAMILY MEMBERS	RELATIONSHIP	SEX	DOB	SS#	COVERED BY PRIMARY INS
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>

AUTHORIZATION AND ASSIGNMENT

I hereby voluntarily consent to outpatient care with Desert Senita Community Health Center, encompassing routine, minor surgical, and diagnostic procedures. I furthermore consent to the performance of examination and procedures by the medical staff and their assistants, including physician assistants, and A.R.N.P.'s. I understand that physician assistants and A.R.N.P.'s are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I also assign the claim payments to be made payable to Desert Senita Community Health Center. I understand any overpayment in my account will be refunded in a timely manner. I agree to the release of information of Medicare, Medicaid, and any third party payors. This authorization and assignment may be revoked by me at any time by written notice.

SIGNATURE: _____ DATE: _____

FAMILY MEMBERS	RELATIONSHIP	SEX	DOB	SS#	COVERED BY PRIMARY INS
CHART NUMBER	NEW PATIENT / UPDATED INFO.	ASSIGNED PROVIDER		INTERVIEWER INITIALS	