Seaside Family Health Center Registration Form

Language Spoken _____

Date of Registration _____ MR# _____

DOB _____/_____/_____ Sex _____ Age _____

Last Name _____ First Name _____ MI _____ Suffix _____

Mailing Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ SSN _____

Ethnicity _____ Country of Birth _____ Year Entered United States _____

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

If patient is a minor complete information below:

Mother's Name _____ SSN: _____ DOB ____/____/____

Father's Name _____ SSN: _____ DOB ____/____/____

Guarantor _____ Relationship to Guarantor _____ Spec. Program _____

DOB _____/_____/_____ SSN _____

Employer _____ Address _____

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

Total Monthly Income _____ Family Size _____

1. Is patient working all year? Yes ☐ No ☐
2. How is family supported when not working? _____
3. Payment method: Bill insurance ☐ Medi-Cal ☐ CPSP ☐ Medicare ☐
   CHDP ☐ PACT ☐ Sliding Scale ☐ Other ☐
4. Eligible for Discount? High ☐ Medium ☐ Low ☐

In case of emergency contact: Name _____

Phone _____ Relationship _____

I certify that the above information is correct and I understand that all fees and charges for services rendered are the responsibility of the patient or guarantor. Charges and fees not covered by the patient's insurance will be billed to the patient or guarantor.

Patient/Guarantor _____ Date _____

Witness _____ Date _____