BeverlyCare - Patient Registration

Pt. Reg., Nov 2020

Patient Name: _____
Last First Middle

Address: _____
Street Apt. # City Zip

Phone #: ( ) _____ ( ) _____ ( ) _____
Home Work Cellular

Do you have a **Social Security Number?** ☐ Yes ☐ No Social Security Number: _____

Is your Social Security # for employment only? ☐ Yes ☐ No Email Address: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female
Month / Day / Year

Living Situation: ☐ Own ☐ Rent ☐ Motel/Hotel ☐ Car/Vehicle ☐ Halfway House/Shelter ☐ Homeless Shelter

☐ Transitional ☐ Street ☐ Permanent Supportive Housing ☐ Other **Are you a Veteran?** ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Sexual Orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Do not wish to disclose **Disabled?** ☐ Yes ☐ No

Ethnicity: ☐ Non Latino /Hispanic ☐ Latino/ Hispanic **Race:** ☐ White ☐ African American ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other ☐ Native Hawaiian

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Do not wish to disclose

Income Period: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annual ☐ Other ☐ Do not wish to disclose

Family Income: Gross Income for Period: $_____ Number of Individuals Income Supports: _____

Employment Information: Employer: _____ Address: _____
Occupation: _____ Phone Number: _____

What language should your information be provided in? _____

How well do you understand English? ☐ Very well ☐ Moderate ☐ Very little ☐ None

Do you have any ALLERGIES? _____

NEXT OF KIN: Friend/Relative to Contact In Case of Emergency: _____ ( ) _____
Name Relationship Telephone #

Parent(s)/Guardian Information (if applicable):

_____ _____ _____ _____
Name Relationship Telephone # DOB

_____ _____ _____ _____
Name Relationship Telephone # DOB

1. Do you have health insurance? ☐ Yes ☐ No If YES, Insurance Name: _____ Policy Number? _____
2. Do you have dental insurance? ☐ Yes ☐ No _____
3. Do you have Medi-Cal? ☐ Yes ☐ No Have you applied? ☐ Yes ☐ No Policy Number? _____
4. Does your child (patient) have CHDP? ☐ Yes ☐ No
5. Do you have FamilyPACT? ☐ Yes ☐ No

I understand that my medical/dental information is confidential. I authorize the exchange of information between BeverlyCare and any other providers or organizations only as necessary for treatment, payment or healthcare related purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available on request. I HEREBY AUTHORIZE TREATMENT BY BEVERLYCARE ☐ Yes ☐ No Initials _____

Patient Signature or guardian (if minor): _____ **Date** _____

Name and relationship (if not patient): _____