Patient Registration Form

www.cfhc.care

Castle Family Health Centers, Inc. is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Not Reported/Refused if you do not wish to answer a specific question. Thank you for choosing Castle Family Health Centers as your health care provider.

Section 1: Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: □ Sr. □ Jr. □ II □ III □ Other: _____ Social Security #: _____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other: _____

Street Address: _____ City: _____ State: _____Zip: _____

Email: _____@ ☐ gmail.com ☐ att.net ☐ yahoo.com ☐ Comcast.net □ aol.com □ _____

Primary Phone: □ Home □ Cell □ Work / Home #: ( ) _____-_____ Cell: ( ) _____-_____

Work #: ( )_____-_____ Primary Language: □ English □ Spanish □ Sign Language □ Other: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian or

Other Pacific Islander ☐ Other: _____ **Primary Doctor**: _____

Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Gender Identity: □ Not Reported/Refused ☐ Female ☐ Male ☐ Transgender Female (Male-to-Female)

□ Transgender Male (Female-to-Male) □ Non-Binary (Identifying as any gender other than female or male)

□ Uncertain □ Other: _____

Sexual Orientation: ☐ Not Reported/Refused ☐ Heterosexual/Straight ☐ Homosexual/Gay/Lesbian ☐ Bisexual

☐ Uncertain ☐ Other: _____

Section 2: Guarantor (Financial Responsible Individual) Information

Guarantor is: ☐ Patient is Guarantor (no need to complete the rest of this section) ☐ Person ☐ Company

Patient's Relation to Guarantor: ☐ Child ☐ Parent ☐ Spouse ☐ Employer ☐ Other: _____

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: □ Sr. □ Jr. □ II □ III □ Other: _____ Social Security #: _____-_____-_____ Sex: □ Male □ Female

Date of Birth: _____/_____/_____ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Primary Language: □ English □ Spanish □ Sign Language □ Other: _____

How did you learn about CFHC? □ Family/Friend □ Physician Referral □ Online □ Newspaper

Section 3: Family Income and Shelter Information

We request income on all patients for governmental reporting purposes. If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application.

Income Period: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

Gross Income for Period: $_____ Number of Individuals Income Supports: ___ ____ Disabled: □ Yes □ No

Homeless Status: ☐ Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other_____

Worker Status: □ Migrant ☐ Not Migrant ☐ Seasonal Veteran: ☐ Yes ☐ No

Section 4: Patient Insurance Information

Insurance Coverage: ☐ Private Insurance ☐ Central California Alliance for Health ☐ Medi-cal ☐ Medicare ☐ None

Primary Insurance Company: _____ Member ID # _____ Group# _____

Primary Subscriber Information:

Last Name: _____ First Name: _____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Parent ☐ Child ☐ Spouse ☐ Other: _____

Address (if different than patient) _____ City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____ Member ID # _____ Group# _____

Secondary Subscriber Name: _____ Date of Birth: _____

Section 5: Emergency Contact Information

Patient Relationship to Contact: ☐ Parent ☐ Child ☐ Spouse ☐ Other: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Address (if different than patient) _____ City: _____St: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Work: _____

Financial Agreement Assignment of Benefits & Authorization for Treatment:

I hereby certify that the above information is true, I authorize any medical treatment, anesthetics or surgical procedures, as the attending physician deems necessary. I hereby authorize my providers to release medical information as required and permitted by law. I understand that I am responsible for payment if charges incurred in the course of treatment. Should this account become delinquent and be referred to any attorney or collection agency, the undersigned will pay actual attorney's fees and collection expenses. A $25.00 fee is charged on all return checks. In addition to cash or check, Visa and MasterCard are accepted.

Patient/Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____