BeverlyCare - Patient Registration

Clinic/Pt. Reg., Jan 2017

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: _____ (Month / Day / Year) Age: _____ Sex: ☐ Male ☐ Female

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

Are you disabled? ☐ Yes ☐ No **Smoke?** ☐ Yes ☐ No **Sexual orientation** ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Do not wish to disclose

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

Education level completed: ☐ Less than high school graduate ☐ High school graduate ☐ Some College/Associate's Degree ☐ Bachelor's degree or higher

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? _____

Friend or Relative to Contact In Case of Emergency: _____ (Name) _____ (Relationship) ( ) _____ (Telephone #)

If minor, mother's name: _____ If minor, father's name: _____

How did you hear of the Clinic? _____

1. Do you have health insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____
2. Do you have dental insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____
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 FPACT? ☐ Yes ☐ No

I understand that my medical/dental information is confidential. I authorize the exchange of information between [clinic] and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available on request.

I hereby authorize treatment by [clinic]. ☐ Yes ☐ No Initials _____

The exchange of information may include treatment for:

Alcohol or drugs ☐ Yes ☐ No Initials _____ Psychiatric drugs ☐ Yes ☐ No Initials _____

Adequate numbers of radiographs are required for proper diagnosis. I consent to performing radiographs as needed for my dental treatment: ☐ Yes ☐ No Initials _____

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

Name and relationship (if not patient)