MADERA COUNTY HEALTH DEPARTMENT – PATIENT REGISTRATION FORM

PLEASE PRINT

FULL NAME: _____

(First) (Middle) (Last) (Suffix)

DATE OF BIRTH: _____/_____/_____

GENDER: Female ____Male ____Decline to Specify ____

MARITAL STATUS: Single____ Married____ Domestic Partner____ Other____

RACE: Caucasian____African American or Black____American Indian____Alaskan Native ____Asian Indian __Chinese ____

Filipino____Japanese____Korean____Vietnamese____Native Hawaiian____Guamanian/Chamorro____Samoan____

Other Pacific Islander____Asian____White ____Declined ____

ETHNICITY: Hispanic/Latino _____ Not Hispanic/Latino ____Declined_____

PREFERRED LANGUAGE: English ___ Spanish ___Chinese ____Arabic __Other _____

PARENT/GUARDIAN NAME: _____

PATIENT ADDRESS: _____

CITY: _____ **STATE:** _____ **COUNTY:** _____ **ZIP CODE:** _____

HOME PHONE #: _____ **MOBILE PHONE #:** _____ **Email Address:** _____

Emergency Contact:

Name: _____ **Relationship** _____ **PHONE:** _____

PREFERRED METHOD OF CONTACT: Home Phone____ Cell Phone ____ Work Phone____ E-Mail____

NEEDS INTERPRETER: Yes _____No_____

ALLERGIES-SEVERITY:

_____

Do you have insurance? Yes _____No_____ If Yes please select: Medi-Cal____ Private Insurance____

Insurance Company: _____ ID#: _____

Plan: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Primary Care Physician: _____ PCP Phone Number: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Relationship with Insured: Self _____ Spouse_____ Child_____ Other_____

REVISED 08/31/2022 CJ