Office use

NOTE: FOR OFFICE USE ONLY **PLEASE "PRINT" INITIALS** **USE BLACK INK ONLY**

REG. CSR:	SCANNING CSR:	PT #:

PATIENT INFORMATION: USE BLACK INK ONLY

Last Name:	First Name:	Middle Int:

Preferred First Name and Last name if applicable: N/A ❑

Date of Birth:	Social Security #: Refused ❑	❑ **Hearing** Impaired ❑ **Vision** Impaired	Sex at Birth: ❑ M ❑ F

Gender: ❑Male ❑Female ❑Female-to-Male/Transgender Male/Trans Man
❑Male-to-Female/Transgender Female/Trans Woman ❑ Genderqueer, Neither Exclusively male or female
❑ Other, Please Specify:_____

Sexual Orientation: ❑ Straight or Heterosexual ❑ Lesbian, Gay or Homosexual ❑ Bisexual
❑ Refused to Report ❑ Unknown ❑ Other, Please Specify:_____

Street Address/City/State/Zip

PO Box or Alternate Address N/A ❑

Home Phone Number:	Cell Phone Number:	Work Phone Number:

Would you like to receive notifications via text message? ❑Yes ❑No Carrier:_____	Would you like to use Patient Portal? ❑Yes ❑No (18+ Only) Email:_____

RESPONSIBLE PARTY/GUARANTOR

Relationship: ❑ Self ❑ Spouse ❑ Parent ❑ Legal Guardian ❑ Caregiver ❑ Other_____

Last Name:	First:	Middle Int:

Date of Birth:	Social Security #: Refused ❑	Sex: ❑ M ❑ F

Street Address: ❑ Same as above	City/State/Zip Code

Home Phone Number: ❑ Same as above	Cell Phone Number: ❑ Same as above	Work Phone Number:

ADDITIONAL PATIENT DATA

Patients Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Life Partner ❑Legally Separated	Patients Student Status: ❑Full-Time ❑Part-Time ❑Not in School

Patients Employment Status: ❑ Disabled ❑Full-Time ❑Part-Time ❑ Retired ❑ Student ❑Unemployed ❑None

Spouse Employment Status: ❑ Disabled ❑Full-Time ❑Part-Time ❑ Retired ❑ Student ❑Unemployed ❑None

Patient Race: ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑Native Hawaiian
❑Other Pacific Islander ❑White ❑Unreported/Refused to Report

Patients Ethnicity: ❑ Hispanic/Latino ❑ Cuban ❑ Another Hispanic, Latino/a or Spanish Origin
❑ Mexican, Mexican American, Chicano/a, ❑ Puerto Rican ❑ Not Hispanic/Latino
❑ Unreported/Refused to Report

Patients Primary Language: ❑English ❑Spanish ❑Arabic ❑Other_____ **Interpreter Needed? ❑Yes ❑No**	Patients Veteran: ❑Yes ❑No

Patients Housing Status: ❑Doubling Up ❑Homeless Shelter ❑Not Homeless ❑Public Housing
❑Street ❑Transitional ❑Unknown ❑Other

Patients Agricultural Status: (*The term agriculture means farming in all its branches, including Cultivation and tillage of the soil. The production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land. The practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market performed by a farmer or on a farm*.)

❑**Dependent of Migrant** (*A person who relies on another, especially a family member, for financial support. In this case, a dependent of a migrant worker)*

❑**Dependent of Seasonal** (*A person who relies on another, especially a family member, for financial support. In this case, a dependent of a seasonal migrant worker*)

❑**Migrant Worker** (*The Term migratory agricultural worker means an individual whose principal employment is in agriculture or an aged or disabled worker, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary home*)

❑**Seasonal Worker** (*Seasonal Agricultural worker means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker*)

❑**Not Agricultural Worker** (*A person who does not work in agriculture or any of its branches*)

PRIMARY CARE PHYSICIAN:

Name:_____ Specialty:_____

Address:_____Phone:_____

Mothers Maiden Name: Refused ❑

Patients Place of Birth: Refused ❑

City: State: Country:

Preferred Pharmacy:

How did you hear about us? ❑Community Event ❑Employee Referral ❑Friend/Family Referral ❑Google ❑Online ❑Yelp ❑ Recall Letter ❑ Other:_____

EMERGENCY CONTACTS/COMMUNICATION

First Name	Last Name	
Home Phone Number:	Cell Phone Number:	Work Number:

Relationship:_____ Type of Contact: ❑Emergency ❑Primary Contact ❑Legal Guardian/Health Care Proxy ❑ Patient Resides with Contact ❑Primary Caregiver

INSURANCE INFORMATION

Primary Insurance: ❑IEHP ❑ Molina ❑ CHG ❑ Care 1st ❑ Medical ❑ Medicare ❑No Insurance Coverage
Commercial Insurance:_____ ❑ HMO ❑ PPO Group #:_____
Policy number:_____ Holder SSN:_____
Patients relationship to insurance holder: ❑ Self ❑Child ❑Spouse ❑Other:_____
Full Name:_____D.O.B:_____

Secondary Insurance: ❑IEHP ❑ Molina ❑ CHG ❑ Care 1st ❑ Medical ❑ Medicare ❑No Insurance Coverage
Commercial Insurance:_____ ❑ HMO ❑ PPO Group #:_____
Policy number:_____ Holder SSN:_____
Patients relationship to insurance holder: ❑ Self ❑Child ❑Spouse ❑Other:_____
Full Name:_____D.O.B:_____

Patient Employer_____Phone:_____

SIGNATURE

I certify that the information on this form is complete and correct:

Forms Completed With the Assistance of a Translator ❑ Yes ❑ No
Translator's Name:

_____ _____
Patient/Guardian Signature Date

Household Assessment Form

Please use this form to provide information on the members of your household. It is necessary to provide this information when registering as a new Borrego Health patient. Updating this information is required once a year, or at any time household information changes during the year. Please include information for all family members living within your household, whether or not they are patients of Borrego Health. Please ask for assistance if necessary.

County: ❑ Riverside ❑ San Diego ❑ San Bernardino Other: _____			❑Refused to Provide
Patient:	DOB:	SSN:	Monthly Income: $
Guarantor:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
Name:	DOB:	SSN:	Monthly Income: $
			***Total Household Income $_____**

SIGNATURE

I certify that the information on this form is complete and correct:

_____ _____

Patient/Guardian Signature *Date*

***Household:** Family members living at the same address
***Family Member:** Any related person living at the Household address
***Total Income:** Total money earned by all family members in the Household
***Monthly:** Total Income paid each month