Castle Family Health Centers

www.castlefamilyhealth.org

Adult Registration Form

PATIENT INFORMATION	RESPONSIBLE PARTY INFORMATION (Parent, Guardian, Spouse, etc.)
Name First Middle Last	Name First Middle Last
Date of Birth _____ (month/day/year) Sex F ☐ M ☐ Primary Language: _____	Relationship _____ Date of Birth _____ (month/day/year) Sex F ☐ M ☐
Social Security #	Social Security #
Primary Phone # (cell/home/msg)	Primary Phone # (cell/home/msg)
Secondary Phone # (cell/home/msg)	Secondary Phone # (cell/home/msg)
Email address	Email address
Mailing Address	Mailing Address
City State Zip	City State Zip
Home Address	Home Address
City State Zip	City State Zip
Employer Name	Employer Name
Address	Address
City State Zip	City State Zip

TO BE COMPLETED BY THE RESPONSIBLE PARTY

Marital Status (please √ one) Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other ☐

Income $ Weekly ☐ Monthly ☐ Yearly ☐ Family Size

Employed in Agriculture Yes ☐ No ☐ If Yes, Seasonal ☐ Or Migrant ☐

Emergency Contact Phone #

Insurance Coverage ☐ Medi-Cal ☐ Medicare ☐ Private Ins. ☐ None ☐ Other _____

Primary Subscriber Info.: Name: _____ D.O.B. _____ Relationship: _____

PLEASE PRESENT YOUR INSURANCE ID CARD

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 provider to release medical information as required and permitted by law. I understand that I am responsible for payment of charges incurred in the course of treatment. Should this account become delinquent and be referred to any attorney or collection agency for collection, the undersigned will pay actual attorney's fees and collection expenses. A $25.00 fee is charged on all returned checks. In addition to cash or check, Visa and MasterCard are accepted.

Patient's Signature _____ Date ___/___/___

Responsible Party's Signature _____ Date ___/___/___

Witness _____ Date ___/___/___