CLINICAS
DEL CAMINO REAL, INCORPORATED

REGISTRATION FORM

How Did You Hear About Us?

Please mark one of the following:

- ❍ Friend/Family Member
- ❍ Website/Internet
- ❍ Newspaper
- ❍ Yellow Pages
- ❍ Radio
- ❍ Mailed Advertisement
- ❍ Insurance Referral
- ❍ Physician Referral (list name):_____
- ❍ Other (please specify):_____

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Social Security #
			_ _

Date of Birth	Gender	Primary Phone Number	Alternative Phone Number/Cellular	Primary Care Provider (PCP):
_____ _____ _____ Month Day Year	☐ Male ☐ Female	( ) -	( ) -	

Address	City	State	Zip Code

Emergency Contact Name _____

Relationship to Patient _____

Phone Number (different from number(s) stated above) ( ) -

E-Mail Address

_____

Are you a veteran of the Armed Forces?

☐ Yes ☐ No

What is your race?

- ☐ American Indian (Including Mixteco) or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White
- ☐ More than one race

Are you of Hispanic/Latino Origin?

☐ Yes ☐ No

Primary Language

- ☐ English
- ☐ Spanish
- ☐ Mixteco
- ☐ Other:_____

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow
- ☐ Separated

Family Size

___ 0 ___ 6
___ 1 ___ 7
___ 2 ___ 8
___ 3 ___ 9
___ 4 ___ 10
___ 5

Estimated Annual Household Income
(For grant reporting purposes only)

$_____

INSURANCE INFORMATION

Name of Primary Insurance	Social Security #
	_ _

Policy Holder Name	Date of Birth	Relationship to Patient
	_____ _____ _____ Month Day Year	☐ Spouse ☐ Parent or Guardian ☐ Other: _____

RESPONSIBLE PARTY INFORMATION IF DIFFERENT THAN PATIENT

Last name	First name	Middle Initial	Relationship to Patient
			☐ Spouse ☐ Parent or Guardian ☐ Other: _____

Date of Birth	Gender	Social Security #
_____ _____ _____ Month Day Year	☐ Male ☐ Female	_ _

Address	City	State	Zip Code

Phone Number	Driver's License Number	State	Marital Status
( ) –			☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

Patient Consent to Treatment

I hereby consent to any necessary medical or surgical treatment, which may include prescribed medications issued by the provider. I understand that even simple treatments or diagnostic measures have a risk of complications. In such cases, further consultation with the provider may be necessary. Clinicas del Camino Real, Inc. will make referrals for specialized services we are unable to provide here.

Signature:_____ **Date:**_____