NOTE: FOR OFFICE USE ONLY		
SCHOOL:	GRADE:	
REG: CSR:	SCANNING CSR:	PT #:

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.
Date of Birth: / /	Social Security Number: / /	Doctor of Record:	Gender: ❑ M ❑ F

Street Address:	Apt:	P.O. Box:	City:

State:	Zip:	Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )

Alternative Address:	From: Month_____	To: Month_____

Would you like to receive notifications via text message? ❑Yes ❑No *Carrier:*_____	E-Mail Address:	Refused ❑

Hearing Impaired ❑	Vision Impaired ❑

RESPONSIBLE PARTY/GUARANTOR

❑Self ❑Spouse ❑Parent ❑Legal Guardian ❑Caregiver ❑Other _____

Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.
Date of Birth: / /	Social Security Number: / /		Gender: ❑ M ❑ F

Street Address:	City:	State:	Zip Code:

Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )

INSURANCE INFORMATION

Primary Insurance Name:	
Policy Holder:	Date of Birth: / /
Secondary Insurance Name:	
Policy Holder:	Date of Birth: / /
Dental Insurance Name:	
Policy Holder:	Date of Birth: / /

HOUSEHOLD ASSESSMENT

Household Total Income $_____

❑Weekly ❑Bi-Weekly ❑Twice a Month ❑Monthly ❑Yearly ❑Daily

Number of Family Members in Household:_____	County: _____		❑ Refused to Provide
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /
Name:	DOB: / /	Income: $_____	SSN: / /

ADDITIONAL PATIENT DATA

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Life Partner ❑Legally Separated

Student Status: ❑Full-Time ❑Part-Time ❑Not in School

Employment Status: ❑Full-Time ❑Part-Time ❑None

Spouse Employment Status: ❑Full-Time ❑Part-Time ❑None

Mother's Maiden Name:

VETERAN: ❑Yes ❑No

Place of Birth City_____State:_____Country:_____

Primary Language: ❑English ❑Spanish ❑Arabic ❑Other_____

Interpreter Needed? ❑Yes ❑No

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

Agricultural Status: ❑Dependent of Migrant ❑Dependent of Seasonal ❑Migrant Worker ❑Not Agricultural Worker ❑Seasonal Worker

Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Unreported/Refused to Report

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

Employer:	Industry:	Occupation:

PREFERRED PHARMACY

Pharmacy Name:	Address:	Phone Number: ( )

PRIMARY CARE PHYSICIAN (if non Borrego Health provider)

Primary Care Physician:_____ Specialty:_____

Address: Phone: ( )

EMERGENCY CONTACTS/COMMUNICATION

Primary: ❑Emergency ❑Primary Contact ❑Legal Guardian/Health Care Proxy ❑Patient Resides with Contact ❑Primary Caregiver

Relationship:
❑Spouse ❑Parent ❑Child ❑Grandparent ❑Aunt ❑Uncle ❑Brother ❑Neighbor ❑Friend ❑Other_____ ❑*No Primary Contact*

First Name:	Middle Name:	Last Name:

Address:	City:	N/A ❑

State:	Zip Code:	Home Phone Number: ( )	Cell Phone Number: ( )

Secondary: ❑Emergency ❑Primary Contact ❑Legal Guardian/Health Care Proxy ❑Patient Resides with Contact ❑Primary Caregiver

Relationship:
❑Spouse ❑Parent ❑Child ❑Grandparent ❑Aunt ❑Uncle ❑Brother ❑Neighbor ❑Friend ❑Other_____ ❑*No Secondary Contact*

First Name:	Middle Name:	Last Name:

Address:	City:	N/A ❑

State:	Zip Code:	Home Phone Number: ( )	Cell Phone Number: ( )

SIGNATURE

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

_____ _____

Patient/Guardian Signature *Date*