

Is the patient covered by a third party payor (Medicaid, Blue Cross, Medicare, Commercial Insurance) that should be billed for services provided? _____ Yes _____ No

If the answer if no, please skip Section II and complete the questions in Section III - "Additional Patient Information Section".

Section II - Insurance Information:

_____	<u>Self</u> <u>Spouse</u> <u>Child</u> <u>Other</u>
Subscriber's Name	Circle the Relationship to the Patient
_____	_____
Name of Insurance Company	Identification Number
_____	_____
Group Name	Group Number

Subscriber's Date of Birth	

Section III - Additional Patient Information:

Please Circle the Patient's Race

Asian Native Hawaiian Other Pacific Islander Black/African American (Not Hispanic or Latino)
American Indian/Alaskan Native White (Not Hispanic or Latino) Hispanic or Latino (All Races) More Than One Race

Please Circle the Patient's Ethnicity

Hispanic/Latino Non Latino

What language is spoken at home? _____

If the patient has been here before, did they have a different name? If so, please enter that name

Is the patient a Veteran? _____ Yes _____ No

Is the patient a Migrant Worker? _____ Yes _____ No

Is the patient Homeless? _____ Yes _____ No

Does the patient require translation services? _____ Yes _____ No

If we need to contact the patient may we do so by the following means?

Telephone Call _____ Yes _____ No

Telephone Message _____ Yes _____ No

Mail _____ Yes _____ No

E-Mail _____ Yes _____ No

To the best of my knowledge, the above information is accurate. I understand that if any of the above information changes, I will notify the Center as soon as possible.

Signature of Patient or Responsible Party _____
Date