

BUTTE COUNTY PUBLIC HEALTH DEPT.

Patient Registration Information

Current Name _____ Birthdate: ____/____/____
Last/First/Middle

Name at Birth _____ Age ____ Gender M F
Last/First/Middle

County of Birth: _____ Mother's First Name _____

Cell Phone (____) _____ Home Phone (____) _____

Mailing Address _____ Work Phone (____) _____

City/State/Zip Code

(Initial) **Please do not contact me at the above phone numbers and/or address**

Please contact me by phone at (____) _____ Message Phone (____) _____

If you are a student, what school do you attend? _____

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Pacific islander White More than one race Other

Ethnicity: Are you Hispanic? Yes No

Marital Status: Married Single Separated Divorced Other

Family Size: Number of adults living in the home? _____ Number of dependent children: _____

Income Level: Gross Monthly Income \$ _____ Income Source _____

Insurance Information: Medi-Cal PACT CMSP Other _____
Do you have private medical insurance? Yes No

The above information is true to the best of my knowledge. I hereby give my consent to any and all services ordered by the attending clinicians for myself or my family member listed above.

- I agree not to hold the Butte County Department of Public Health, or any of its employees, liable for any act or omission in following their instructions.
- I consent to phone calls and mail from Public Health to the above listed numbers and address unless otherwise noted above.
- I hereby authorize my insurance and/or Medi-Cal to pay benefits to which I am entitled directly to Butte County.
- I accept responsibility for payment of services not covered by Medi-Cal or my insurance and authorize the mailing of bills for such services to the address indicated above.
- I understand that other departments within the Butte County Public Health may access my medical record and share my immunization records with schools, hospitals, daycare's and other County Health Departments.

Client Signature/Legal Guardian	Date	Staff Signature	Date
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Relationship if not signed by patient: _____

Is this your first visit to the clinic? No Yes, Please tell us how you learned of our services....

- | | | | | |
|---|-----------------------------------|--|--|---|
| <input type="checkbox"/> Friend / Family | <input type="checkbox"/> Employer | <input type="checkbox"/> Teacher / Counselor | <input type="checkbox"/> The ARC | <input type="checkbox"/> Homeless Shelter |
| <input type="checkbox"/> Case Worker at Department of Social Services | | | <input type="checkbox"/> Phone Book | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Case Worker at _____ | | | <input type="checkbox"/> Saw a Brochure or Flyer | |
| <input type="checkbox"/> Heard a presentation at: _____ | | | <input type="checkbox"/> OCOT / Teen Scene | |
| <input type="checkbox"/> Other (please describe) | | | <input type="checkbox"/> 6 th St Drop-In Center | |

