



# REGISTRATION FORM

PATIENT LABEL HERE

## Patient Information

Last Name		First Name		Middle Name	
Alias or Maiden Name		Sex	Birth Date	Social Security #	Marital Status
Street Address		City		State	Zip Code
Preferred Language	Need Interpreter <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Decline		Race <input type="checkbox"/> Black or African American <input type="checkbox"/> American India or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pac. Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline	
Home Phone		Work Phone		Cell Phone	Email
Employer Name		Employment Staus <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student		Retirement Date (if applicable)	Occupation
Emergency Contact Name		Emergency Contact Number		Relationship	
Primary Care Provider Name		Primary Care Provider Phone #	Referred? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred by Name/Phone #	

## Guarantor/Legal Guardian (if different than above)

Last Name		First Name		Middle Name		Relation to Patient
Alias or Maiden Name		Sex	Birth Date	Social Security #	Marital Status	
Street Address		City		State	Zip Code	
Preferred Language	Need Interpreter <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Decline		Race <input type="checkbox"/> Black or African American <input type="checkbox"/> American India or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pac Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline		
Home Phone		Work Phone		Cell Phone		
Employer Name		Occupation		Employment Status		

## Primary Insurance

Insurance Company Name		Group Number		Subscriber ID Number		Copay Amount
Subscriber's Name		Social Security Number		Date of Birth	Sex	Relationship to Patient
Subscriber's Employer Name		Subscribe Employment Status		Home Phone		Work Phone

## Secondary Insurance

Insurance Company Name		Group Number		Subscriber ID Number		Copay Amount
Subscriber's Name		Social Security Number		Date of Birth	Sex	Relationship to Patient
Subscriber's Employer Name		Subscribe Employment Status		Home Phone		Work Phone

### CONSENT TO CARE:

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that Pacific Medical Centers participates in the training of physicians and other healthcare providers and I will be told when trainees take part in my care.

### NOTIFICATION OF RELEASE FOR PAYMENT:

I understand that Pacific Medical Centers will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

### FINANCIAL AGREEMENT:

I understand co-payments are due at the time of service. I assign payment from my insurance directly to Pacific Medical Centers. I understand I am financially responsible to Pacific Medical Centers for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider. I may also receive separate bills from the laboratory, radiology and other specialized services.

### RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES:

I have received a copy of the Pacific Medical Centers **Notice of Health Information Practices** which provides information about how my health information may be used and disclosed.

I have read the above and understand its contents:

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

- Data entered into Epic
- Insurance card scanned
- Drivers license/picture ID scanned

Parent or Guardian: \_\_\_\_\_

**Medicare**

Medicare Number: \_\_\_\_\_ Part A  Part B

**MEDICARE QUESTIONNAIRE – Required for all Medicare Patients  
MSP Information**

1. Are you over 65 years of age and is this why you have Medicare Part B benefits? ..... Yes / No
2. Are you employed right now? ..... Yes / No
3. Is your spouse employed right now? ..... Yes / No
4. Are you covered by a health plan from your own or family member's current employment? ..... Yes / No  
↳ Does the employer have 20 or more employees? ..... Yes / No
5. Are you or your spouse retired? ..... Yes / No  
↳ Your retirement date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
↳ Spouse's retirement date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
↳ Spouse's name: \_\_\_\_\_
6. Do you have Medicare because of end stage renal disease (ESRD)? ..... Yes / No  
↳ Is ESRD the reason you first became eligible for Medicare? ..... Yes / No  
↳ Are you within the first 30 months of treatment for ESRD? ..... Yes / No
7. Is the reason you have Medicare due to a disability, other than ESRD? ..... Yes / No  
↳ Are you covered by a group health plan of an employer with over 100 employees? ..... Yes / No
8. Has the Department of Veterans Affairs (VA) authorized and agreed to pay for the services at this facility today? ..... Yes / No  
Note: VA benefits are separate from TRICARE medical coverage. A "yes" answer means the VA sent you here today.
9. Were you a coal miner and are you entitled to benefits under the Federal Black Lung Program? ..... Yes / No
10. Is this illness or injury due to a work related accident, and will your bill today be sent to a Workers' Compensation Carrier primary to or instead of Medicare? ..... Yes / No
11. Is this illness or injury the result of a non-work related accident (i.e. motor vehicle accident)? ..... Yes / No  
↳ Do you have non-fault or liability insurance (i.e. auto insurance) that we should bill instead of Medicare for your services today? ..... Yes / No
12. Are services to be paid by a government research program? If yes, please provide billing instructions to the front desk ..... Yes / No

May we leave detailed health information on a voicemail for you? Yes \_\_\_\_\_ No \_\_\_\_\_ (Place "X" on the line).  
If yes, please provide us with a phone number in which we may leave a message: Cell / Home / Work \_\_\_\_\_  
On occasion, patients may wish to have a family member or close personal friend assist them with matters related to their care. Please provide us with the full name and relationship of any individual (other than yourself) who you permit PMC to discuss your limited and/or detailed billing and health information with:  
Name of individual: \_\_\_\_\_ Relationship: \_\_\_\_\_  
-OR- Do NOT allow disclosure to any other individual: \_\_\_\_\_ (Place "X" on the line).

Pacific Medical Centers complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

中文 (Chinese)  
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-4PACMED (TTY: 711)。

Tiếng Việt (Vietnamese)  
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-4PACMED (TTY: 711).

Español (Spanish)  
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-4PACMED (TTY: 711).

\*\*We value your privacy and may share your contact information with trusted partners to assist us in enhancing your experience with PacMed. Your medical information is never shared.