University | Centers of Excellence

In affiliation with UCSF Fresno

Patient Registration Form

Please print and complete ALL sections. Missing information may result in charges billed directly to the patient. - **PATIENT INFO PG.1**

Last Name:	First Name:	Middle Name:
Also known as or maiden name:		
Marital Status: ☐ Single ☐ Married	**Date of Birth:**	Age:
Sex: ☐ M ☐ F ☐ Prefer not to specify	**Social Security #:***	
Race: ☐ Black/African American ☐ White/Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native ☐ Asian ☐ Unknown ☐ Other_______________ ☐ Prefer not to specify		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other: _______________ ☐ Prefer not to specify		
Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Lao ☐ Punjabi ☐ Hearing Impaired/Sign ☐ Vietnamese ☐ Other:_______________ ☐ Prefer not to specify		
Preferred Phone #:		☐ Home ☐ Cell ☐ Work
Second Phone #:		☐ Home ☐ Cell ☐ Work
Street Address:		P.O. Box/Apt #:
City:	State:	Zip:
E-mail Address:		
Employer:	Phone #:	
Primary Care Physician:	Phone #:	
Did a Physician refer you to this office or did you choose this office yourself? ☐ Physician ☐ Self		
If a Physician, please state who:		
Preferred Pharmacy:	Phone #:	
Pharmacy Location/Cross Streets:		

INJURY INFORMATION - Date of Injury:

Non-Work Related Injury: ☐ Yes ☐ No	Work Related Injury: ☐ Yes ☐ No

IN CASE OF AN EMERGENCY

Emergency Contact:	Relationship to Patient:
Home Phone #:	Work Phone #:

*University Centers of Excellence's new electronic medical record system (EMR) requires your social security number as your unique identification number. Please help us provide you with the highest quality of care by sharing your social security number. This is very important because without your social security number as an identifier, your electronic medical record may not be complete or may contain inconsistencies. Please be confident your social security number is used only used for this purpose — it is never printed out. It is protected from misuse just as we protect your health information.

Patient Registration Form *Continued*

Please print and complete ALL sections. Missing information may result in charges billed directly to the patient. - **PATIENT INFO PG. 2**

Last Name:	First Name:	Middle Name:

INSURANCE INFORMATION - Please give your insurance card to the receptionist.

Guarantor Information: ☐ Check here if same as patient

Responsible Party:	Date of Birth:
Address *(if different from patient)*:	Home Phone #:
Occupation: Employer:	
Employer Address:	Phone #:

PRIMARY INSURANCE - Insurance Company Name:

Subscriber's Name:		Subscriber's SSN #:
Date of Birth:	Group #:	Policy #:
Co-pay: $	Patient's relationship to subscriber: Self-01 Spouse-02 Child-03 Other:	

SECONDARY INSURANCE (IF APPLICABLE) - Insurance Company Name:

Subscriber's Name:		Subscriber's SSN #:
Date of Birth:	Group #:	Policy #:
Patient's relationship to subscriber: ☐Self-01 ☐ Spouse-02 ☐ Child-03 ☐ Other:		
Is this a worker's compensation claim: ☐ Yes ☐ No		

Medicare Secondary Reason Code *(Must check one if Medicare is Secondary):*

- ☐ 12 **Working Aged** Beneficiary or Spouse with Employer Group Health Plan
- ☐ 13 End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
- ☐ 14 No-fault Insurance including Auto is Primary
- ☐ 15 Worker's Compensation
- ☐ 16 Public Health Service (PHS) or Other Federal Agency (Government Research Program)
- ☐ 41 Black Lung
- ☐ 42 Veteran's Administration
- ☐ 43 **Disabled** Beneficiary Under Age 65 with Large Group Health Plan (LGHP—Employers with 50+ employees)
- ☐ 47 Other Liability Insurance is Primary (Homeowners)

What is your preferred method of communication for appointment reminders?

☐ Phone ☐ Regular Mail ☐ Web Portal ☐ Text Message ☐ Do Not Contact

PRIVACY CLAUSE: A person is liable for constructive invasion of privacy when they attempt to capture, any type of visual image, sound recording, or other physical impression of another individual engaging in a personal or familial activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than $5,000 and not more than $50,000 [California Civil Code, Section 1708.8].Central California Faculty Medical Group (CCFMG) and University Centers of Excellence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

____ ____________________________

Patient/Guardian Signature Date