Patient Registration

Delta Health Center, Inc.

Date

Language
- ☐ English
- ☐ Spanish
- ☐ Indian
- ☐ Chinese
- ☐ Other

Translator Needed?
- ○ yes
- ○ no

Are you a veteran? ☐ yes ☐ no

Patient/Account Information

Last Name

First Name

Date of Birth

Social Security Number

Address

E-mail address

City

Phone Number

State

Zip Code

Sex
- ○ Male
- ○ Female

Marital Status
- ○ Single
- ○ Married

Responsible Party
*Complete this section if the responsible party is different from the patient.

Last Name

First Name

Date of Birth

Social Security Number

Address

Place of Employment

City

Cell Phone

State

Zip Code

Insurance

Do you have insurance?

○ yes ○ no

Insurance Type

☐ Private ☐ Medicaid

☐ Medicare ☐ Children's Health Insurance Program

☐ Other

Name of Insurance

Group Number

Member Number

Subscriber

Relationship to Subscriber

Address of Insurance Carrier

City, State, & Zip Code

Phone

Secondary Insurance

Group Number

Member Number

Address of Insurance Carrier

City, State, & Zip Code

Phone

Pharmacy

Location & Phone

Emergency Contact

Name

Relationship

Address

Phone

City

State

Zip code

Employer's Address

Employer's Name

Position

Street address

Work Phone

City

State

Zip code

Residence Type

- ☐ Residential Home
- ☐ Skilled Nursing Home
- ☐ Private Home
- ☐ Nursing Home

Characteristic

- ☐ Homeless
- ☐ Migrant
- ☐ Seasonal
- ☐ Transitional
- ☐ Doubling Up
- ☐ Other

Race or Ethnicity

- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ Pacific Islander
- ☐ Hispanic
- ☐ Other

Name of Family Members

Income Enter Dollar Amount

***Sliding Fee Discount is available for patients who qualify.**

Patient Signature

Date

Parent or Guardian's Signature

Date