Sunshine Community Health Center

Patient Information and Registration

Patient Information

Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Primary Phone: ____________________
Alt Phone: ____________________
Mobile Phone: ____________________

Patient ID#: ____________________ Sex:
Date of Birth: ____________________ Age: __________
E-Mail Address: ____________________
Social Security #: ____________________
Marital Status:
Veteran Status:
Race:

Patient Employment Information

Employment Status:
Employer's Name: ____________________
Employer's Phone: ____________________
Occupation: ____________________

Emergency Contacts

Name	Relationship	Phone

Responsible Party (If Patient is under 18 years of age)

Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: ____________________

Employer: ____________________
Work Phone: ____________________
SSN: ____________________
Date of Birth: ____________________

Primary Insurance

Insurance Company Name: ____________________
ID#: ____________________
Group/Policy#: ____________________
Subscriber's Name: ____________________
Subscriber's Phone #: ____________________
Subscriber's Employer: ____________________
Subscriber's SS #: ____________________
Subscriber's Date of Birth: ____________________

Secondary Insurance

Insurance Company Name: ____________________
ID #: ____________________
Group/Policy #: ____________________
Subscriber's Name: ____________________
Subscriber's Phone #: ____________________
Subscriber's Employer: ____________________
Subscriber's SS #: ____________________
Subscriber's Date of Birth: ____________________

Work Related Injury

Only Applicable if injury is related to work or auto accident

Insurance Carrier Name: ____________________
Address: ____________________ City, State, Zip: ____________________
Phone: ____________________ Employer at time of Injury: ____________________
Claim Number: ____________________ Date of Injury: __________

I request SCHC to provide me and/or my family member with medical care. I acknowledge my responsibility to pay for care according to the fees established, whether or not paid by insurance. I authorize the release of any medical or other information necessary to process insurance claims. I assign directly to SCHC all insurance benefits, if any, otherwise payable to me for service rendered. If my provider prescribes controlled substances, I give SCHC permission to gather information regarding controlled substances prescriptions past and present from other providers and pharmacies.

____________________ Signature ____________________ Relationship ____________________ Date