



# Castle Family Health Centers

3605 Hospital Road, Suite H, Atwater, CA, 95301

Telephone (209) 381-2000

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

(Last, first, mi)

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_--\_\_\_\_ Message Phone: ( ) \_\_\_\_--\_\_\_\_ Primary Language Spoken \_\_\_\_\_

Social Security Number: \_\_\_\_--\_\_\_\_--\_\_\_\_ Marital Status:  Single  Married  Divorced  Widow

Ethnicity:  Asian  Native Hawaiian  Other Pacific Islander  Black African American – Not Hispanic

American Indian/ Alaska Native  Hispanic or Latino—All Races  White—Not Hispanic or Latino  Unreported/Refused to Report

**Please check one of the following (For patients 18 years old):**

Migrant Agricultural Worker  Seasonal Agricultural Worker  Not Applicable

## Responsible Party (If patient is under 18 years old)

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_--\_\_\_\_ Message Phone: ( ) \_\_\_\_--\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_--\_\_\_\_ Message Phone: ( ) \_\_\_\_--\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Legal Guardian/Conservator's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_--\_\_\_\_ Message Phone: ( ) \_\_\_\_--\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

***(All legal documentation appointed by the court must be presented at the time of visit)***

Emergency Contact person: \_\_\_\_\_ Phone number: \_\_\_\_\_

Insurance Type (Please mark appropriate coverage)

Medi- Cal  Medicare  Private Insurance  Self Pay  Worker's Comp. Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please Circle Order of Insurance ( 1. Primary 2. Secondary 3. Third)

**FINANCIAL AGREEMENT ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR TREATMENT:** I hereby certify that the above information is true. I authorize any medical treatment, anesthetics or surgical procedures, as the attending physician deems necessary. I hereby authorize my provider to release medical information as required and permitted by law I understand that I am responsible for payment of charges incurred in the course of treatment. Should this account become delinquent and be referred to an attorney or collection agency for collection, the undersigned will pay actual attorney's fees and collection expenses. A \$25.00 fee is charged on all returned checks. In addition to cash or check, Visa and Mastercard are accepted

### If signed by someone other than patient or patient's parent, please state your legal relationship:

Legal Guardian  Foster Parent  Adult Under Conservatorship  Power of Attorney  If emancipated minor (check box)

Patient Signature/Parent/Legal Guardian (if minor): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_