GOLDENRULE FAMILY PRACTICE

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www.goldenrulemd.com
Portal direct site: https://health.healow.com/goldenrule

REGISTRATION FORM

PATIENT INFORMATION - INFORMACION DEL PACIENTE

Patient Name
nombre del paciente _____ DOB
fecha de nacimiento _____

Race
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Other Pacific Islander
- ☐ Prefer Not to Answer

Ethnicity
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer Not to Answer

(State and Local governments may use the data to help plan and administer bilingual programs for people of Hispanic origin.)

Preferred Language - Lenguage de Preferencia
☐ English ☐ Spanish ☐ Other _____

☐ Communication Needs ☐ Sign Language ☐ Vision ☐ Other

Current Address - Direccion
_____
_____
_____

Zip Code
codigo postal _____

Home Phone
casa telefone ( ) _____

Work Phone
trabajo telefone ( ) _____

Cell Phone
celular telefone ( ) _____

Preferred Phone (mark box below)
☐ Home ☐ Work ☐ Cell

Employment Status - Empleo
- ☐ Full Time
- ☐ Part Time
- ☐ Not Employed
- ☐ Self Employed
- ☐ Occupation _____
- ☐ Retired
- ☐ Military Duty
- ☐ Disabled
- ☐ Student

Sex
- ☐ Male
- ☐ Female
- ☐ Other

Martial Status
- ☐ Single - Soltero
- ☐ Married - Casado
- ☐ Divorced - Divorciado
- ☐ Widow/Widower - Viuda
- ☐ Separated - Separdo

Email Address
direccion electronico _____

How did you hear about this clinic? _____
como nos en contraste

Allergies (please list all your allergies) _____
alergias (por favor enumere todas las alergias)

Preferred Pharmacy _____ Telephone Number _____
farmacia de preferencia numero de telefono

Intersection / Cross Streets _____
direccion

_____ _____
Patient Signature
firma del paciente

Date
fecha

_____ _____
Signature of Authorized Person
firma de la persona autorizada

Date
fecha

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REGISTRATION FORM (contd.)

PERSON TO NOTIFY IN EMERGENCY / PRIMARY CARE GIVER
A QUIEN PODEMOS LLAMAR EN CASO DE UNA EMERGENCIA

Primary Care Giver is a person who provides day to day care for the patient and receives instructions about care.

Name _____
nombre

Relationship to Patient _____
relacion del paciente

Sex M / F DOB _____
fecha de nacimiento

Home Phone ( ) _____
casa telefone

Work Phone ( ) _____
trabajo telefone

Cell Phone ( ) _____
celular telefone

POWER OF ATTORNEY

Do you have a healthcare power of attorney (POA) or advanced directives: ( ) Yes, ( ) No.

Name of POA _____

Relationship with POA _____ POA phone no. _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT
(GUARANTOR IF PATIENT IS UNDER 18 YRS OF AGE)
NOMBRE DE LA PERSONA RESPONSABLE DE LA CUENTA

☐ Same as patient
mismo como paciente

DOB _____
fecha de nacimiento

Sex M / F

Legal Name _____
nombre

☐ Address is same as patient
dirección es la misma que el paciente

Street _____ Apt # _____
direccion

City _____ State _____ Zip Code _____
ciudad estado codigo postal

Relationship to Patient _____
relacion del paciente

PERSON WHO CARRIES THE INSURANCE FOR THE PATIENT
(SUBSCRIBER)
PERSONA ENCARGADO DE LA SEGURANSA

☐ Same as patient
mismo como paciente

DOB _____
fecha de nacimiento

Sex M / F

Legal Name _____
nombre

☐ Address is same as patient
dirección es la misma que el paciente

Street _____ Apt # _____
direccion

City _____ State _____ Zip Code _____
ciudad estado codigo postal

Relationship to Patient _____
relacion del paciente

Social Security Number _____
seguro social

The subscriber's social security number is required for on line billing.