SYLMAR MEDICAL CENTER

PATIENT REGISTRATION FORM

DATE:

PATIENT INFORMATION				
LAST NAME:	FIRST NAME:	MI	[ ] FEMALE [ ] MALE	
ADDRESS:	CITY:	STATE:	ZIP	
HOME PHONE:	CELL PHONE#:	DATE OF BIRTH:	SOCIAL SECURITY#:	
MARITAL STATUS [ ] S [ ] M [ ] W [ ] D	REFERRED BY:			

RESPONSIBLE PARTY INFORMATION	
NAME:	RELATIONSHIP TO PATIENT: [ ]MOTHER [ ]FATHER [ ]LEGAL GUARDIAN [ ]STEP PARENT
EMPLOYER INFORMATION:	WORK PHONE#:

INSURANCE INFORMATION		
PRIMARY INSURANCE COMPANY:		
LAST NAME:	FIRST NAME:	MI
RELATIONSHIP TO PATIENT:	GROUP#:	MEMBER ID#:
SECUNDARY INSURANCE COMPANY:		
LAST NAME:	FIRST NAME:	MI
RELATIONSHIP TO PATIENT:	GROUP#	MEMBER ID#

EMERGENCY CONTACT INFORMATION			
NAME:	RELATIONSHIP:		
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE#:		

LANGUAGE AND LINGUISTIC NEEDS	
PRIMARY LANGUAGE:	SECUNDARY LANGUAGE:
INTERPRETER SERVICES NEEDED: [ ] YES [ ] NO	IS PATIENT HEARING IMPAIRED? [ ] YES [ ] NO

ADVANCE DIRECTIVES

DO YOU HAVE AN ADVANCE DIRECTIVE? [ ] YES [ ] NO IF YES PLEASE PROVIDE A COPY

WOULD YOU LIKE INFORMATION REGARDING ADVANCE DIRECTIVES? [ ] YES [ ] NO

ASSIGNMENT OF BENEFITS, AUTHORIZATION OF TREATMENT, & CONSENT TO TREAT MINOR

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to the physician/facility on record. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I hereby request and consent to diagnostic procedures, including CHDP examinations, X-rays, blood test, medical treatments, including immunizations and dental treatments deemed advisable by the professional staff of Sylmar Medical Center, I acknowledge that I have read this consent form and understand its contents. I have had the opportunity to discuss it, and any questions I have had have been answered to my complete satisfaction

Being the parent/legal guardian of the above minor I consent to the said procedures being performed whether I am present or not and this, my signature hereunder, shall be full and sufficient authority. Should the need arise to perform services not set out above, Sylmar Medical Center may obatain consent by telephone or by letter granting such consent.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN:	DATE: