CLIENT ID #_____

PATIENT'S REGISTRATION RECORD

TODAY'S DATE _____/_____/_____

DMV /AIN /SSN_____/_____/_____ DATE OF BIRTH _____/_____/_____

NAME _____
(LAST) (FIRST) (MIDDLE NAME)

ADDRESS _____APT # _____CITY _____ STATE ____ ZIP CODE _____

PRIMARY RESIDENCE PHONE #(_____)_____-_____BEEPER/CELLPHONE/WORK/OTHER PHONE # (_____)_____-_____

RACE ____ HISPANIC ORIGIN Y/N SEX ___ MARITAL STATUS ___ EDUCATION STATUS _____SCHOOL _____
COUNTRY_____ (Last grade completed)

LANGUAGE _____ REGISTERED VOTER ___Y___/___N___

AVOID HOME CONTACT? YES ( ) NO ( ) RELATIONSHIP TO HEAD OF HOUSEHOLD _____

GUARANTOR'S NAME _____SOCIAL SECURITY NUMBER _____-_____-_____

GUARANTOR'S ADDRESS (if different from above) _____

CITY _____ STATE _____ ZIPCODE _____

GUARANTOR'S TELEPHONE NUMBER (_____)_____-_____

DOES THE PATIENT HAVE HEALTH INSURANCE COVERAGE?* YES ( ) NO ( ) MEDICAID?* YES ( ) NO ( )

NAME OF PLAN	POLICY/GROUP NUMBER	NAME OF INSURED	RELATIONSHIP	EFFECTIVE DATE	END DATE
MEDICARE				/ /	/ /
MEDICAID				/ /	/ /
CHAMPUS				/ /	/ /
BC/BS				/ /	/ /
				/ /	/ /

*WE WILL NEED TO MAKE A COPY OF YOUR HEALTH INSURANCE CARD FOR OUR RECORDS. THANK YOU.

04/99 (REGFORMVISION.1) ASSISTED BY OSS STAFF (INITIALS): _____

EMERGENCY CONTACT: RELATIONSHIP TO PATIENT_____

NAME _____ PHONE NUMBER (_____) _____ - _____ EXT. _____
LAST NAME FIRST NAME

STREET ADDRESS _____

CITY_____ STATE _____ ZIPCODE _____

I certify that the information provided is a true and complete statement according to my best knowledge and belief. In applying for payment by Medicare,

Medicaid and other health care benefits, I authorize release of records necessary to act on this, and request that payment of authorized benefits be made

in my behalf. I give my permission for me or my dependents to be interviewed, examined, and treated.

_____ _____ _____
DATE SIGNATURE RELATIONSHIP

*WE WILL NEED TO MAKE A COPY OF YOUR HEALTH INSURANCE CARD FOR OUR RECORDS. THANK YOU.

 ASSISTED BY OSS STAFF (INITIALS): _____