SHINGLE SPRINGS
Health & Wellness Center
Health Care for All

Purchased/Referred Care
Registration Form

SECTION 01 | Patient Demographics

First_____ Last _____

Middle name _____ Suffix _____

Date of birth _____/_____/_____ Social security number _____-_____-_____

Marital status (Circle one) Single Married (Spouse's Name)_____

Widowed Divorced Separated Decline to Answer

Phone number (home)_____ (cell phone)_____ (email)_____

SECTION 02 | Emergency Contact

First _____ Last _____

Street address _____

City, State, Zip Code _____

Phone number (_____)_____ Relationship to patient _____

SECTION 03 | Patient Information

Are you employed? (Circle one) Yes No

Employer name_____

Is your spouse employed? (Circle one) Yes No

Employer name_____

Are you a college student?_____ If yes, Full time_____ Part time_____

SECTION 04 | Please list any PRC eligible minor children (under 18) residing in your household

Name	Date of Birth	Tribe	Documentation Provided (Y/N)

SECTION 05 | Insurance Information

Do you have health Insurance? (Circle one) Yes No

If yes, what types of do you have? (Circle all that apply)

Medical Dental Vision Prescriptions

Medical Insurance Name_____

Dental Insurance Name_____

Vision Insurance Name_____

Prescription Insurance Name_____

Are you eligible for any other third party Insurance programs? (Circle one) Yes No I don't know

SECTION 06 | Patient Signatures

I certify the information provided to the Shingle Springs Health & Wellness Center (facility) is complete and accurate. I understand if any information changes, it is my responsibility to provide the facility with the updated information.

I understand that if the facility makes unnecessary or improper payments on my behalf, based on the information I provided, that I may be responsible for the payment or share of cost, and I may be ineligible for Purchased/Referred Care (PRC) in the future.

Print name* _____

Signature of Patient or Guardian*_____Date* _____

I have received a copy of the Purchased/Referred Care policies and procedures.

Print name* _____

Signature of Patient or Guardian*_____Date* _____

SECTION 07 | Employee Signatures

(Office Use Only)

Print name* _____

Signature*_____Date* _____