

**REGISTRATION/ REGISTRO TODAY’S DATE/** *Fecha de hoy \_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_

**PATIENT’S INFORMATION/*INFORMACIÓN DEL PACIENTE***

**FIRST NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MIDDLE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LAST NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nombre Segundo nombre/inicial Apellido*

**DOB/*Fecha de nacimiento*** *-* **M/D/Y -***M/D/A* \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **SS#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SEX/***Sexo* 🞎**M** 🞎**F ADDRESS/*Dirección*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*# and Street/ Número y Calle City/Ciudad State/Estado Zip/Código Postal*

**HOME PHONE/** *Teléfono de casa* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CELL/** *Celular* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORK/OTHER PHONE** *Trabajo/Otro teléfono (Whose?/¿Quién?)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Do you use email regularly?** 🞎**Yes/*Sí*** 🞎**No**

*Correo electrónico* **­­­­­­­­­­­­­­­** *¿Usa usted correo electrónico con regularidad?*

**EMPLOYER /** *Empleador \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***OCCUPATION /**O*cupación*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT STATUS/** *Empleo* 🞎Full-Time 🞎Part-time 🞎Self-employed 🞎Retired 🞎Unemployed 🞎Student

 *Tiempo completo Medio tiempo Cuenta propia Retirado Desempleado Estudiante*

**MARITAL STATUS/** 🞎Single🞎Married 🞎Widowed 🞎Divorced 🞎Separated 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Estado Civil Soltero Casado Viudo Divorciado Separado Otro*

**GUARANTOR INFORMATION** (If patient under the age of 18) **/ *INFORMACIÓN DEL RESPONSABLE****(Si paciente es menor de 18 años)*

**FIRST NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MIDDLE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LAST NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nombre Segundo nombre/inicial Apellido*

**DOB/***Fecha de nacimiento-* **M/D/Y** *M/D/A* \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **SS#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SEX/***Sexo* 🞎 **M** 🞎 **F ADDRESS/*Dirección***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*# and Street/ Número y Calle City/Ciudad State/Estado Zip/Código Postal*

**HOME PHONE /** *Teléfono de casa* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CELL** / *Celular* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORK/OTHER PHONE** *Trabaja/Otro teléphono (Whose?/¿Quién?)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RELATIONSHIP/** *Relación* **🞎Parent** *Padre/Madre* **🞎Grandparent** *Abuela/o* **🞎Foster Parent** *Guardián* **🞎Other** *Otro* \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL/***Correo electrónico \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* **EMPLOYER/** *Empleador*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE/*SEGURO***

**PRIMARY INSURANCE COMPANY/** *Compañía de seguro primario*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS THIS INSURANCE “CHIP” FOR A CHILD?** *¿Este seguro es "CHIP" para un niño?* 🞎 **YES/SI 🞎 NO**

**ID NUMBER/** *Número de ID*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GROUP NUMBER /***Número de grupo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**INSURED PERSON’S RELATIONSHIP TO PATIENT/***Relación asegurado y paciente* **🞎Self/** *Me* **🞎Spouse/** *Cónyuge* **🞎Parent/** *Padre*

**IF INSURED PERSON IS NOT “SELF”, COMPLETE THE FOLLOWING:** *Si la persona asegurada no es usted mismo, complete lo siguiente:*

**INSURED’S NAME/** *Nombre asegurado*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH/** *Fecha de nacimiento*\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS #** \_\_\_\_\_\_\_- \_\_\_\_- \_\_\_\_\_\_\_

**SECONDARY INSURANCE COMPANY** *Compañía de seguro secundario*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ID NUMBER/** *Número de ID*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GROUP NUMBER/** *Número de grupo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**INSURED PERSON’S RELATIONSHIP TO PATIENT/** *Relación asegurado y paciente* **🞎Self/** *Me* **🞎Spouse/** *Cónyuge* **🞎Parent** *Padre*

**IF INSURED PERSON IS NOT “SELF”, COMPLETE THE FOLLOWING:** *Si la persona asegurada no es usted mismo, complete lo siguiente:*

**INSURED’S NAME/** *Nombre asegurado*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH/** *Fecha de nacimiento*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS #** \_\_\_\_\_\_\_- \_\_\_\_- \_\_\_\_\_\_\_

**ARE YOU ON THE READING HEALTH SYSTEM PAYSCALE PROGRAM? 🞏 Yes/Si 🞏 No**

**OTHER IMPORTANT INFORMATION/*INFORMACIÓN IMPORTANTE***

1. **PHARMACY NAME/ADDRESS /** *Nombre Farmacia /dirección*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **EMERGENCY CONTACT/** *Contacto en emergencia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**RELATION/** *Relación*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ph#/***Tel. #*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Live with patient?/** *¿Vive con paciente?* **🞎Yes/Si 🞎No**

1. **Does the patient have an Advance Health Care Directive?** 🞎 **Yes** 🞎**No If yes, have you given us a copy?** 🞏 **Yes** 🞏 **No**

*¿Tiene el paciente una Directiva Por Anticipado de Atención a la Salud?* **🞎 Sí 🞎 No** *Si es así, nos has dado una copia?* **🞎 Sí 🞎 No**

1. **How did you hear about BCHC?** ¿Cómo se enteró acerca de BCHC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Registration Form 1-27-13\_REVISED\_NM