**Frontera Healthcare Network**
**Patient Registration Form**

**Patient Information**

Name: _____ DOB: _____

Street Address/P O Box _____ Email _____

City: _____ State: _____ Zip Code: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Social Security Number: _____ Marital Status: _____ Sex: M F

Sexual Orientation: Other _____ Gender Identity: Other

Veteran? Y N Student? Y N Employed? Y N Retired? Y N

___ Hispanic / Latino ___ All other Race: _____

Language in which you are best served: _____

**Head of Household Information**

Name: _____ DOB: _____

Street address / PO Box: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Pharmacy name: _____ Location: _____

Phone number: _____

**Person to contact in case of emergency**

Name: _____ Relationship: _____

Cell phone: _____ Home phone: _____ Work phone: _____

*I hereby authorize the following individual(s) to consent to treatment or services and to verbally give and receive protected health information regarding any treatment or service rendered at FRONTERA HEALTHCARE CENTERS. If any changes occur to this authorization, it will be my responsibility to notify FRONTERA HEALTHCARE CENTERS. Individual(s) listed below must be 18 years of age or older and have a photo I.D.*

| Name | Relationship | Name | Relationship |
|---|---|---|---|
| 1. _____ | | 3. _____ | |
| 2. _____ | | 4. _____ | |

*I certify the above information is true and correct. If information is falsified, I am responsible for payment of services.*

_____ _____ _____

Patient / Parent / Guardian Date Witness