Georgetown Office
21444 Carmean Way, Georgetown, DE 19947
P#: (302) 855-1233-- F#: (302) 654-1061

La Red HEALTH CENTER
Rooted in Community

REGISTRATION FORM

☐ **Milford Office** ☐ **Seaford Office**
☐ **Seaford Gyn**

PATIENT INFORMATION

Chart# _____ Account #:_____
Name: _____
Address: _____
P.O. Box: _____
City: _____ State: _____ Zip-Code: _____

Are You Enrolled in HCC? Yes [ ] No [ ]
Primary Language: _____

Race: _____
Ethnic Group**:** _____
Country of Birth:

Home Phone #:_____
Work Phone #: _____
Cell Phone #: _____
Can We Leave You A Voice Mail Message?
Marital Status: _____
Sex: _____ Date of Birth: _____ MM/DD/YY
Referring Physician: _____

Emergency Contact: _____
Emergency Contact Phone #: _____
Contact Relationship: _____
Can We Leave A Voice Mail Message With Them? Yes [ ] No[ ]
Are You A Veteran? Yes [ ] No[ ]

E-Mail Address: _____

Student [ ] Employed [ ] Self Employed [ ] Unemployed [ ] Retired [ ] Employer Address: _____
Employer:_____ City:_____ State:____ Zip-Code:_____
Employer Phone Number:

INSURANCE INFORMATION

Primary Insurance: _____
Effective Date: _____/_____/_____ MM/DD/YY
Subscriber Name: _____
Certificate #: _____
Group Name: _____
Group #: _____
Policy Telephone #: _____
Patient's Relationship: Self [ ] Spouse [ ] Child [ ] Other [ ]
Subscriber's DOB: _____ SSN#:_____

Secondary Insurance: _____
Effective Date: _____/_____/_____ MM/DD/YY
Subscriber Name: _____
Certificate #: _____
Group Name: _____
Group #: _____
Policy Telephone #: _____
Patient's Relationship: Self [ ] Spouse [ ] Child [ ] Other [ ]
Subscriber's DOB:_____ SSN#:_____

PARENT/ LEGAL GUARDIAN INFORMATION

Name(First, MI, Last): _____
Address : _____
P.O. Box: _____
City:_____ State:____ Zip-Code:_____
Social Security #:_____-____-_____

Sex:_____ Date of Birth: _____MM/DD/YY
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
Relationship to Child: _____

I certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at the time of service unless other arrangements have been made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health insurance carrier or payer of my health benefits may pay less than the actual bill for services, and I am ultimately responsible for any balances. I authorize my provider to release any information necessary for my course of treatment or requested by my insurance carrier. I have been offered and/or received a copy of the HIPAA polices of La Red Health Center.

_____ _____ ____/____/____
Patient's Signature (Guardian if patient is under 18) Print Date

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Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

Please Check Appropriate Box	Please Check Appropriate Box(es)
Sex: □ Female □ Male □ Choose not to disclose	**Race:** □Black/African American □Asian Indian □Chinese □Vietnamese □Guamanian □Native Hawaiian □American Indian/Alaska Native □Other Pacific Islander □Choose not to disclose □White □Other Asian □Japanese □Korean □Samoan □Filipino
Please Check Appropriate Box(es) **Housing Status:** □Own / Rent If renting, circle one: House, Apartment, Room □Transitional Housing □Doubling up (multiple families) □Homeless If homeless, circle one: shelter, street, other	Please Check Appropriate Box(es) **Ethnicity:** □Non-Hispanic, Non-Latino, Non-Spanish □Hispanic, Latino, or Spanish □Cuban □Puerto Rican □Mexican, Mexican American, Chicano □Choose not to disclose **Primary/Preferred Language:** _____
Please Circle Your Answer Do you live in Public Housing? Yes / No Are you a Veteran? Yes / No Are you a Migrant worker? Yes / No Are you a Seasonal worker? Yes / No	

As a Federally Qualified Health Center, we are required to collect the above information.
Thank you for helping us comply.

Staff only:
Please enter Patient Self Declaration income level: Level _____
Staff initials: _____