Frontera Healthcare Network
Patient Registration Form

Email: _____

Patient Information

Name: _____ DOB: _____

Street Address/P O Box _____

City: _____ State: _____ Zip Code: _____

Cell phone: _____ Work phone: _____ Religion: _____

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

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

_____ Hispanic / Latino _____ All other Race: _____

Language in which you are best served: _____

Primary Doctor _____ _____**Phone #** _____

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