REGISTRATION FORM

Date: _____

_____ _____ _____
Patient Last Name First Name Middle Initial

Date of Birth: _____ [ ] Male [ ] Female

Social Security: _____

Medicare No.:_____Medical No.: _____

Patient Address

Street Address: _____

City: _____ State: ____ Zip Code: _____

Home Phone: _____Cellphone: _____

Marital Status

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Employment Status

[ ] Employed [ ] Full-time Student [ ] Part-time Student [ ] Unemployed [ ] Retired

Race (Optional)

[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American
[ ] Native Hawaiian or Pacific Islander [ ] Other: _____

Ethnicity

[ ] Cuban [ ] Hispanic/Latino [ ] Mexican, Mexican-American [ ] Not Latino or Hispanic [ ] Puerto Rican [ ] Unknown

Religion:_____

Linguistic Services Needs

Primary language: _____ Secondary Language:_____
Interpreter services offered: [ ] Yes [ ] No Interpreter Services Accepted: [ ] Yes [ ] No

Interpreter Services Provided By:[ ]PCP [ ]Other Is Patient Hearing Impaired:[ ]Yes[ ] No

Employer Information

Employer Address: _____

City: _____ State:____ Zip Code: _____

_____

Employer Phone Number: _____

Occupation:_____

Emergency Contact Information

Name: _____ Relationship:_____

Phone Number:_____ Cell Phone:_____

Address: _____

City: _____ State: CA Zip Code: _____

Authorization:

I hereby authorize *Community Health Care Center/ Dr. Martin Zapata* to be my attending physician and to administer to me any examination, treatment and medications he/she deems therapeutic to my present complaint. I hereby authorize *Community Health Care Center/ Dr. Martin Zapata* to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the doctors all payment for medical services.

Date: _____

Signature of Patient/Parent/Guardian: _____

Patient Name:_____

DOB:_____

Dr. Martin R. Zapata
11865 Firestone Blvd. Norwalk, CA 90650 **Tel:** (562) 806-1214 **Fax:** (562) 806-1218