SANTA LUCIA MEDICAL GROUP, INC.

1336 Natividad Rd., Salinas, CA 93906

(831) 754-4444

PATIENT REGISTRATION INFORMATION

Acct.# _____

LAST NAME	FIRST	MI	DATE OF BIRTH/	MM	DD	YY

	SEX	AGE	STUDENT STATUS	
	M F		(F)	(P)

ADDRESS:

Home _____ Apt.# _____ City _____ State _____ ZIP _____

Billing _____ City _____ State _____ ZIP _____

Home # _____ Cell # _____ Work # _____

Employer _____ Name of Insurance _____

S.S. # ____ - ____ - ____ I.D. or Driver's Lic. # _____

If Married, Spouse Name _____ Birthdate _____

Employer _____ Name of Insurance _____

S.S. # ____ - ____ - ____ I.D. or Driver's Lic. # _____ Wk # (___) _____

IF MINOR, who does child reside with? Father   Mother   Parents   or Guardian   (Please fill out if under parents insurance)
Circle one

Marital Status   S   M   W   D   SEP

Name of Father/Guardian _____ Birthdate _____

Employer _____ Name of Insurance _____

S.S. # ____ - ____ - ____ I.D. or Driver's Lic. # _____ Wk # (___) _____

Name of Mother/Guardian _____ Birthdate _____

Employer _____ Name of Insurance _____

S.S. # ____ - ____ - ____ I.D. or Driver's Lic. # _____ Wk # (___) _____

WHAT OTHER NUMBER MAY WE CALL TO LEAVE A MESSAGE? (DIFFERENT FROM HOUSEHOLD)

Name _____ Relationship _____ (___) _____

NAME OF AUTHORIZED ADULT TO BRING YOUR CHILD TO THEIR APPOINTMENT IF YOU ARE NOT AVAILABLE. IF THE ADULT IS NOT LISTED BELOW, THEN A PARENTAL CONSENT IN WRITING IS NECESSARY SO YOUR CHILD MAY BE SEEN.

Name _____ Relationship _____ (___) _____

Name _____ Relationship _____ (___) _____

I authorize payment of medical benefits to go directly to the physician or supplier and hereby authorize you to disclose to the Benefits Administrator information regarding my present illness or injury. This information is to assist the claims examiner in evaluating claims. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of Father/Mother/Guardian _____ Date: _____

Preferred Language: Spanish ☐   English ☐

Allergic to any Medication or Drugs _____ /which pharmacy & where: _____

Initials _____