# SANTA LUCIA MEDICAL GROUP, INC.

1336 Natividad Rd., Salinas, CA 93906
(831) 754-4444

# PATIENT REGISTRATION INFORMATION

**Acct.#** ______________

| LAST NAME | FIRST | SEX M F | MI | DATE OF BIRTH \| MM \| DD \| YY |
|---|---|---|---|---|
| | | | | |

| OTHER NAMES USED: LAST NAME | FIRST NAME | SEX M F | DOB | SS# |
|---|---|---|---|---|
| | | | | |

**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 (Circle one) (Please fill out if under parents insurance)

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 Patient/Father/Mother/Guardian** ______ **Date:** ______

**Preferred Language:** **Spanish** ☐ **English** ☐

**Allergic to any Medication or Drugs** ______ **Preferred pharmacy & address:** ______

**Initials** ______