



HealthWorks

www.healthworksgcc.com

REGISTRATION FORM

DO YOU WANT TO KEEP THIS CONFIDENTIAL? YES NO

IF YES, PLEASE PROVIDE US WITH A NUMBER THAT WE CAN CONTACT YOU AT OR LEAVE A MESSAGE. THANK YOU.

Today's Date:	Primary Care Provider:
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PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Social Security no.:	Home phone no.: ()
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P.O. box:	City:	State:	ZIP Code:
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Occupation:	Employer:	Employer phone no.: ()
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How did you hear of our clinic? (please check one box):	<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other

How can we contact you?	Can we leave a message?	Can we send you mail?
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Have you been seen at HealthWorks before?

INSURANCE INFORMATION

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ()	Other phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HealthWorks of the Central Coast or insurance company to release any information required to process my claims.

Patient/Witness

Date:

Staff/Witness

Date