NORTH EAST
MEDICAL SERVICES
東 北 醫 療 中 心
a california health+ center

NEMS #:

NAME:

DOB:

REGISTRATION FORM

Please Use Black Ink

NAME: ____ BIRTHDATE: _____/______/_________
Last *First* *Middle*

ADDRESS: ______________________________ CITY: ______________ STATE: _____ ZIP: __________

HOME PHONE: _____________________ CELL PHONE: _____________________

EMAIL ADDRESS: ___________________________ REFERRED TO NEMS BY: ___________________

SEX: ☐ Male ☐ Female ☐ Transexual Male ☐ Transexual Female ☐ Other

SEXUAL ORIENTATION: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Other

ENGLISH LEVEL: ☐ Good ☐ Fair ☐ Little ☐ None DIALECT(S) SPOKEN: _____________________

ETHNICITY: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

RACE/ETHNIC GROUP (Check all that apply):

Asian (Please specify):

☐ Chinese ☐ Asian Indian
☐ Vietnamese ☐ Japanese
☐ Filipino ☐ Korean
☐ Burmese ☐ Other: __________

☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American
☐ American Indian/Alaskan Native
☐ White

STUDENT STATUS: ☐ Full-Time ☐ Part-Time ☐ Not a Student

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

MEDICAL PAYMENT STATUS (Check all that apply):

☐ Self-Pay ☐ Medicare ☐ Medi-Cal ☐ Other: __________
☐ Private Insurance (Please provide copy of insurance card)

PARENTS' INFORMATION (Complete if patient is under 18) :

Father's Name: ____ DOB: _____________

Mother's Name: ____ DOB: _____________

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: ______________________________ Phone #: _________________

Relationship: ____

NEMS #:

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I hereby authorize North East Medical Services (NEMS) to provide health services to the above-named person and authorize insurance benefits to be paid directly to NEMS. I understand that I am ultimately responsible for all charges incurred, including any payments and deductibles required by my health insurance or as provided under NEMS' Sliding Fee Discount Program if I do not have health insurance. I understand that NEMS does not provide on-site emergency services. Furthermore, I hereby authorize the release of pertinent medical information to insurance carriers, if applicable.

I understand that NEMS is required by law to report any assault, abuse, and worker's injury to the proper authorities.

I understand that psychosocial information will be shared with my NEMS provider as needed to maintain total care.

I understand that the picture of the above-named person will be placed on the NEMS Member Identification (ID) Card.

I acknowledge that I have received a copy of NEMS' Notice of Privacy Practices. I understand that I may exercise my rights as described in the notice.

I understand that NEMS may contact me as described in its Notice of Privacy Practices and send messages related to treatment, treatment alternatives or other health-related benefits and services that may be of interest. I understand that I may change how NEMS contacts me or opt-out of certain communications at any time by calling NEMS at (415) 391-9686.

I acknowledge that I have received a copy of the NEMS Member Handbook and have read, understand, and had the opportunity to ask questions about the contents of the handbook.

_______________________________________ _______________________________________
Signature of Patient or Legal Representative | Relationship to Patient

_______________________________________ _______________________________________
Signature of Witness | Date

Notes:
*Text messages are not encrypted and may be read or intercepted by someone else. If someone has your phone, they may be able to read your messages.
** Standard text message, data, and minute usage rates from your mobile or internet service provider may apply.

STAFF USE ONLY: If the patient refused to sign, please check box, initial and date:

☐ **REFUSAL TO SIGN** **Staff Initials:** ____________________ **Date:** ____________________