

CLINIC SERVICES REGISTRATION

PATIENT INFORMATION					
Today's Date:		Date of Birth:		Mother's First Name:	
First name		Middle Initial		Last Name	
Patient Name:					
Street		City		Zip Code	
Address:					
Phone Number:			Relation to Patient:		
First name		Middle Initial		Last Name	
Parent / Guardian Name (if minor):					
Emergency Contact Name:			Relation:		Phone Number:
Primary Care Physician Name:					
Race:		Sex: ☐ Male ☐ Female		☐ Married ☐ Single/Separated ☐ Divorced ☐ Widowed	
Ok to receive mail? ☐ Yes ☐ No		Ok to call you? ☐ Yes ☐ No		Ok to text you? ☐ Yes ☐ No	
INSURANCE INFORMATION					
Primary Insurance Name:			Policy #:		Group #:
REASON FOR VISIT (Circle all that apply)					
Immunizations (Shots)	☐	Immigration	☐	Medical Marijuana Program	☐
Travel Immunizations	☐	Cocci Testing (Valley Fever)	☐	HIV Testing / Results	☐
Yellow Card Purchase (\$)	☐	TB Testing / Results	☐	STD Screening / Treatment	☐
Child Exam / Follow-up	☐	Rash	☐	Family Planning/Birth Control	☐
Other:					
IMMUNIZATION SERVICES (Complete this section for all immunization services)					
Do you have a Yellow Immunization card with you today? ☐ Yes ☐ No					
Do you have any other immunization records with you today? ☐ Yes ☐ No					
STD and/or FAMILY PLANNING Services (Complete this section for all STD/Family Planning services)					
Do you currently have any symptoms of infection? ☐ Yes ☐ No					
Are you currently ABLE to have children? ☐ Yes ☐ No					
Have you previously had a Tubal Ligation / Vasectomy? ☐ Yes ☐ No					
Are you Pregnant? ☐ Yes ☐ No					

Grounded in Health

1800 Mt. Vernon Ave., Bakersfield, CA. 93306 | 661.321.3000 | www.kernpublichealth.com

FINANCIAL DISCLOSURE / FAMILY INCOME

Information disclosed on this form allows the Kern County Public Health Services Department to apply the **sliding fee scale**, based on your disclosed income, to charges for qualified services provided to you. All information is strictly confidential.

☐ I **do not** wish to disclose our family income. I understand that I will be responsible for all charges according to the established fee policy and charges **will not be discounted**.

☐ I **do** wish to disclose our family income. I understand charges for services provided are based on the established fee policy and **can be** discounted based on my disclosed income as stated in the chart below.

- List all family members living in your household and supported by the family income.
- List the sources of all income for EACH family member listed and the amount of income, including Employment, Self-employment, Tips, Social Security, Child/Spousal Support, Ongoing Insurance Payments, Disability, Veterans Affairs, Unemployment Benefits, etc.

Name	Relation to you	Age	Source of Income	Gross Income Amount	How Often Paid
					Weekly/Bi-Weekly/Monthly
					Weekly/Bi-Weekly/Monthly
					Weekly/Bi-Weekly/Monthly
					Weekly/Bi-Weekly/Monthly
					Weekly/Bi-Weekly/Monthly
			Total Family Size:	Total Family Income: \$	

I certify that the above information is correct to the best of my knowledge. Payment is required in FULL on the day of service. In the event payments are not made on my account, any balance will be turned over for collections.

Signature:

Date:

ASSIGNMENT OF BENEFITS

I hereby assign and convey directly to Kern County Department of Public Health Services, as my designated authorized representative reimbursement (if any) including Medicare, otherwise payable to me for any services rendered or provided by Kern County Department of Public Health Services, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of applicable insurance or benefit payments. I hereby authorize Kern County Department of Public Health Services to release all medical information necessary to process my claims.

Signature:

Date:

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

CONSENT FOR TREATMENT

I certify that the above information is true and correct to the best of my knowledge. Furthermore, I authorize Kern County Public Health Services Department to render reasonable and proper medical care for my clinical needs.

Signature:

Date:

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