COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT

General Registration Form

Please complete the following information:

Last Name	First Name	Middle Initial	Nickname
Gender ____Male ____Female ____Non-Binary ____Choose Not to State			Birthdate (MM/DD/YY)
Home Address			Mother's First Name
City	State		ZIP
Phone Number __cell __home __work	Email		Preferred Language
Ethnicity ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ Native Hawaiian or Other Pacific Islander ___ Hispanic ___ White ___ Choose Not to State ___ Other:			
Emergency Contact	Phone	Relationship	

For office use only:

Athena #	CAIR #	Guarantor

Adult

____Self Pay
____Medi-Cal
____CenCal
____Medicare
____State General Fund
____Waived
____Voucher
____Merck
____317
____Private Insurance Provider: _____

Child

____Self Pay - Private Pay
____Medi-Cal VFC
____CenCal VFC
____Uninsured - VFC Self Pay
____State General Fund
____Waived
____Voucher
____Private Insurance Provider: _____

Notes:

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Información de Paciente

Por favor complete la siguiente información:

Apellido	Nombre	Inicial del Segundo Nombre	Apodo
Género ____Masculino ____Femenina ____No binario ____Se elige no declarar			Fecha de Nacimiento (MM/DD/AA)
Domicilio			Nombre de la Madre
Ciudad	Estado		C.P.
Teléfono __celular __casa __trabajo	Correo Electrónico		Idioma Preferido
Etnicidad ___ Indígena norteamericano o Nativo de Alaska ___ Asiático ___ Negro o Afroamericano ___ Nativo Hawaiano u Otro Isleño del Pacífico ___ Hispano ___ Blanco ___ Elige no declarar ___ Otro:			
Contacto de Emergencia	Teléfono	Relación	

For office use only:

Athena #	CAIR #	Guarantor

Adult

____Self Pay
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____CenCal
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Child

____Self Pay - Private Pay
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____State General Fund
____Waived
____Voucher
____Private Insurance Provider: _____

Notes: