Casa Esperanza Registration Form

Room # _____ Date in:_____ Date out:_____

Patient's Name_____ D.O.B. _____ SSN:_____Sex (M / F)
Address:_____City, State _____ Zip_____ County_____
Phone Number:_____ Cell Phone Number: _____

We appreciate your answers to the following questions. Casa Esperanza provides equal opportunity housing and depends on contributions for support. Some of our potential funding sources give generously to agencies who can provide accurate information regarding the following:

African American__ Caucasian__ Hispanic__ Native American__ (Tribe_____) Other_____
Cancer _____ Non-cancer _____ Condition _____
Referral made by _____ Bill to _____
Hospitalized (Yes / No) If so what hospital? _____ Dates _____
Physician _____ Physician's Phone # _____
Name of responsible party: _____ Relationship to patient:_____
Address _____ City/State _____ Zip _____
Emergency Contact:_____ Phone # _____
Auto Year/make/model:_____ License plate:_____

List below the names, ages and relationships to the patient of ALL guests staying in your room at Casa Esperanza Include the patient if he/she is staying at Casa Esperanza.

Name_____ Age_____ Relationship to patient_____ Sex (M / F)
Name_____ Age_____ Relationship to patient_____ Sex (M / F)
Name_____ Age_____ Relationship to patient_____ Sex (M / F)
Name_____ Age_____ Relationship to patient_____ Sex (M / F)
Name_____ Age_____ Relationship to patient_____ Sex (M / F)

I have been given a copy of the house rules and regulations and agree to assume responsibility for my group's compliance with them. I understand that Casa Esperanza assumes no responsibility for the physical or medical care of any member of my group, including the patient and that any patient in need of such support must provide his/her own caregiver. I agree to take the appropriate precautions to protect my valuables and personal items. I fully understand that Casa Esperanza is not responsible for personal injuries, illness or loss of valuables and that I enter Casa Esperanza at my own risk. I further understand that information concerning medical patients may be exchanged between the hospital and Casa Esperanza.

I hereby consent to and authorize the use and reproduction by you, or anyone authorized by you, of any and all photographs which will be taken of either me, my family or my friends, negative or positive, for the purpose of public education and/or fundraising for Casa Eperanza, without further compensation to me. All negatives and positives ,together with the prints shall constitute Casa Esperanza's property, solely and completely.

If I come and register with Casa Esperanza and I decide I am not going to keep the room that night, Casa Esperanza reserves the right to keep my $15.00 deposit as an administrative fee

Signature:_____ Date:_____

Amount Received	Amount Paid	Purpose/Comments	By	Date