Patient Registration Form

Please present this form with your insurance card and photo ID.
Complete the entire form. For areas that do not apply to the patient, enter "N/A".

Patient's Name **Social Security Number:**			**Date of Birth (mm/dd/yyyy):**	
Mailing Address Street and Apartment Number	City	State	Zip	County
Physical Address Street and Apartment Number ☐ Same as mailing	City	State	Zip	County

1st Phone: ☐ Cell ☐ Home ☐ Work OK to leave message ☐ Yes ☐ No	**2nd Phone:** ☐ Cell ☐ Home ☐ Work OK to leave message ☐ Yes ☐ No
Email Address: OK to send secure email message ☐ Yes ☐ No	**Text Message (enter phone number):** Receive text message opt out ☐ Yes ☐ No

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name	**Relationship**	**Phone Number** ☐ Cell Phone ☐ Home Phone ☐ Work

Do you have medical or dental insurance? Please present your insurance card to the Front Desk.
☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ No Insurance ☐ Other_____

Primary Medical Insurance Plan	**Policy Number**
Secondary Medical Insurance Plan	**Policy Number**
Dental Insurance Plan	**Policy Number**

Parent/Guardian Name (First MI Last)	**Parent/Guardian Date of Birth (mm/dd/yyyy) / /**

Parent/Guardian Address Street and Apartment Number ☐ Same as patient	City	State	Zip	County

Parent/Guardian Employer Name	**Parent/Guardian Work Phone**

How did you hear about us?
☐ Family/Friend ☐ Shelter ☐ Health Department ☐ Hospital ☐ Facebook ☐ Instagram ☐ Twitter/X
☐ Internet Search ☐ TV ☐ Radio ☐ Mail ☐ Other_____

Race (check all that apply)	**Do you identify as having Hispanic, Latino/a, or Spanish origin?**	**Gender Identity**	**Sexual Orientation**
☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan ☐ Guamanian or Chamorro ☐ Asian ☐ Vietnamese ☐ Filipino ☐ Korean ☐ Japanese ☐ Asian Indian ☐ Chinese ☐ Decline to Answer	☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, Another Hispanic, Latino/a, or Spanish origin ☐ No ☐ Decline to Answer	☐ Male ☐ Female ☐ Transgender Man/ Transgender Male/ Transmasculine ☐ Transgender Woman/ Transgender Female/ Transfeminine ☐ Other ☐ Decline to Answer **Sex Assigned at Birth** ☐ Male ☐ Female	☐ Heterosexual (or straight) ☐ Lesbian or Gay ☐ Bisexual ☐ Unknown ☐ Decline to Answer

Preferred Language			**Are interpreter services needed?**
☐ English	☐ Spanish	☐ Chinese	☐ Yes
☐ Arabic	☐ Vietnamese	☐ Other: _____	☐ No

Do you live in Public Housing? ☐ Yes ☐ No **Are you a Veteran?** ☐ Yes ☐ No

Homeless Status

☐ **Not Homeless**

☐ **Shelter** (organized shelter)

☐ **Street** (living outdoors, encampment, care, makeshift housing)

☐ **Doubling Up** (person who is living with others; arrangement generally considered temporary and unstable)

☐ **Permanent Supportive Housing** (persons transitioning from homelessness to permanent or housing support programs within the last 12 months)

☐ **Transitional Housing** (transitioning from a homeless environment, do not include jail, institutional treatment programs, military, schools, or other institutions)

☐ **Yes** ☐ **No** **Migrant Farm Worker** – Individual who is required to be absent from a permanent place of residence for the purpose of seeking remunerated employment in agricultural work.

☐ **Yes** ☐ **No** **Seasonal Farm Worker** – Individual who is employed in temporary farm work but does NOT move from their permanent residence to seek work; they may also have other sources of employment.

Please <u>circle the range below</u> indicating the estimated annual household income of the patient according to the number of people living <u>in the patient's home</u>. Advance Community Health is required to report this information to the federal government, and it helps us to better understand the needs of the communities we serve. No identifying information will be disclosed to the federal government. Your anonymity is protected.

	Annual Household Income					
1	*$0 - $15,060*	*$15,061 - $18,825*	*$18,826 - $22,590*	*$22,591 - $26,355*	*$26,356 - $27,861*	*More than $27,862*
2	*$0 - $20,440*	*$20,441 - $25,550*	*$25,551 - $30,660*	*$30,661 - $35,770*	*$35,711 - $37,814*	*More than $37,815*
3	*$0 - $25,820*	*$25,821 - $32,275*	*$32,276 - $38,730*	*$38,731 - $45,185*	*$45,186 - $47,767*	*More than $47,768*
4	*$0 - $31,200*	*$31,201 - $39,000*	*$39,001 - $46,800*	*$46,801 - $54,600*	*$54,601 - $57,720*	*More than $57,721*
5	*$0 - $36,580*	*$36,581 - $45,725*	*$45,726 - $54,870*	*$54,871 - $64,015*	*$64,016 - $67,673*	*More than $67,674*
6	*$0 - $41,960*	*$41,961 - $52,450*	*$52,451 - $62,940*	*$62,941 - $73,430*	*$73,431 - $77,626*	*More than $77,627*

Would you like information on our Sliding Fee Discount Program? ☐ **Yes** ☐ **No**

Patient Registration Disclosures and Consent

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

Assignment of Insurance Benefits
I hereby authorize direct payment of my insurance benefits to Advance Community Health for services rendered to my dependents or me by the provider. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Advance Community Health is unable to collect from by the insurance carrier for whatever reason.

Health Insurance Portability and Accountability Act (HIPAA)
I hereby authorize the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations. I understand the identity of designated parties must be verified before the release of any information. I also understand these parties will have access of all of my protected health information including substance abuse, mental health, STI, AIDS and HIV records. I understand that I may revoke this authorization at any time by notifying the providing organization in writing.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization to Mail, Call, Email or Text
I certify that I understand the privacy risks of the mail, phone call, email, and text. I hereby authorize Advance Community Health or my provider to mail, call, email, or text me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Advance Community Health to that effect in writing.

Authorization to Release Non-Public Personal Information
I certify that I have received and read a copy of Advance Community Health's Privacy Practices of the date on the signature below. I hereby authorize Advance Community Health to release any of my or my dependents medical or non-public protected health information as described in the Privacy Practices that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. I understand that I retain the rights granted to me through Advance Community Health's Privacy Practices. I hereby consent to Advance Community Health's Privacy Practices.

Lab/X-Ray/Diagnostic Services
I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Consent to Treatment
I hereby consent to evaluation, testing, and treatment as directed by Advance Community Health providers.

Patient or parent/guardian signature: _____ Date: _____

Printed name if signed on behalf of the patient: _____ Date: _____

Relationship if signed on behalf of the patient: _____ Date: _____