

**Patient Registration Form**

**ATTENTION:** Please provide copies of insurance cards at time of registration. If you do not have insurance or need assistance in paying for services, you will need to complete a Sliding Fee Application which is available at the front desk.

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Zip \_\_\_\_\_ County \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female  
 Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Email \_\_\_\_\_

**May We Leave Messages regarding the following:**

Appointments, pre-medication and instruction appointments?  Yes  No  
 Medical or Dental information?  Yes  No  
 Information about our Sliding Fee Discount Program?  Yes  No

**Marital Status:**  Single  Married  Divorced  Widowed  Separated

**Employment Status:**  Full-time  Part-time  Self-employed  Retired  Unemployed

**Student Status:**  Full-time  Part-time  N/A **Military Status:**  Active  Retired  Veteran  N/A

**Race** (Please choose one):  White/Caucasian  Asian  Black/African American  American Indian/Alaskan Native  
 Other Pacific Islander  Native Hawaiian

**Ethnicity** (Please choose one):  Hispanic/Latino  Non-Hispanic or Latino

**Primary Language:**  English  Spanish  Other \_\_\_\_\_ **Are Interpretation Services Needed?**  Yes  No

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Do you currently receive public housing?**  Yes  No

**Emergency Contact** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Responsible Party (parent/guardian/person who will pay the bill). If patient is responsible party, skip this section.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address same as Patient  If Not: Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female Phone # \_\_\_\_\_

**Insurance Policyholder:**  Yes  No **Employer** \_\_\_\_\_

**Patient's Relationship to Responsible Party:**

Spouse  Child  Foster Child  Grandchild  DHS Custody  Other \_\_\_\_\_

**Insurance Information**

**Primary Insurance** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address same as Patient  If Not: Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender:  Male  Female Phone # \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address same as Patient  If Not: Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender:  Male  Female Phone # \_\_\_\_\_ Employer \_\_\_\_\_

## Gender Identity

- None
  Identifies as Female
  Male
  Female to Male
  Male to Female  
 Genderqueer neither exclusively Male nor Female  
 Additional gender category or other please specify \_\_\_\_\_  
 Choose not to disclose

## Sexual Orientation

- None
  Lesbian, Gay or Homosexual
  Straight or Heterosexual
  Bisexual
  Don't Know  
 Something else, please describe \_\_\_\_\_  
 Choose not to disclose

## Living Situation

Do you consider yourself homeless?  Yes  No

If yes, what definition would best describe your living situation?

- Shelter
  Street
  Doubled Up (Temporarily living with others.)  
 Transitional Housing (Temporary housing and supportive services to transition from homeless to permanent housing.)  
 Other (Single room occupancy hotels/motels, day to day paid for housing, etc.) \_\_\_\_\_

## Please Select Your Household Size and Your Estimated Yearly Gross Household Income:

Household Size	Yearly	Yearly	Yearly	Yearly	Yearly
1	<input type="checkbox"/> 0-\$12,490	<input type="checkbox"/> \$12,491-\$17,486	<input type="checkbox"/> \$17,487-\$21,649	<input type="checkbox"/> \$21,650-\$24,980	<input type="checkbox"/> \$24,981+
2	<input type="checkbox"/> 0-\$16,910	<input type="checkbox"/> \$16,911-\$23,674	<input type="checkbox"/> \$23,675-\$29,311	<input type="checkbox"/> \$29,312-\$33,820	<input type="checkbox"/> \$33,821+
3	<input type="checkbox"/> 0-\$21,330	<input type="checkbox"/> \$21,331-\$29,862	<input type="checkbox"/> \$29,863-\$36,972	<input type="checkbox"/> \$36,973-\$42,660	<input type="checkbox"/> \$42,661+
4	<input type="checkbox"/> 0-\$25,750	<input type="checkbox"/> \$25,751-\$36,050	<input type="checkbox"/> \$36,051-\$44,633	<input type="checkbox"/> \$44,634-\$51,500	<input type="checkbox"/> \$51,501+
5	<input type="checkbox"/> 0-\$30,170	<input type="checkbox"/> \$30,171-\$42,238	<input type="checkbox"/> \$42,239-\$52,295	<input type="checkbox"/> \$52,296-\$60,340	<input type="checkbox"/> \$60,341+
6	<input type="checkbox"/> 0-\$34,590	<input type="checkbox"/> \$34,591-\$48,426	<input type="checkbox"/> \$48,427-\$59,956	<input type="checkbox"/> \$59,957-\$69,180	<input type="checkbox"/> \$69,181+
7	<input type="checkbox"/> 0-\$39,010	<input type="checkbox"/> \$39,011-\$54,614	<input type="checkbox"/> \$54,615-\$67,617	<input type="checkbox"/> \$67,618-\$78,020	<input type="checkbox"/> \$78,020+
8	<input type="checkbox"/> 0-\$43,430	<input type="checkbox"/> \$43,431-\$60,802	<input type="checkbox"/> \$60,803-\$75,279	<input type="checkbox"/> \$75,280-\$86,860	<input type="checkbox"/> \$86,861+
9	<input type="checkbox"/> 0-\$47,850	<input type="checkbox"/> \$47,851-\$66,990	<input type="checkbox"/> \$66,991-\$82,940	<input type="checkbox"/> \$82,941-\$95,700	<input type="checkbox"/> \$95,701+
10	<input type="checkbox"/> 0-\$52,270	<input type="checkbox"/> \$52,271-\$73,178	<input type="checkbox"/> \$73,179-\$90,601	<input type="checkbox"/> \$90,602-\$104,540	<input type="checkbox"/> \$104,541+
11	<input type="checkbox"/> 0-\$56,690	<input type="checkbox"/> \$56,691-\$79,366	<input type="checkbox"/> \$79,367-\$98,263	<input type="checkbox"/> \$98,264-\$113,380	<input type="checkbox"/> \$113,381+
12+	<input type="checkbox"/> 0-\$61,110	<input type="checkbox"/> \$61,110-\$85,554	<input type="checkbox"/> \$85,555-\$105,924	<input type="checkbox"/> \$105,925-\$122,220	<input type="checkbox"/> \$122,221+

**Payment Agreement:** I hereby certify that the above information is true. I understand that I am expected to promptly and fully pay for services provided by River Hills Community Health Center according to the fees established including co-pays and deductibles.

**Assignment of Benefits:** I hereby assign and authorize direct payment to River Hills Community Health Center of all insurance coverage or other benefits under any government program, any insurance policy or plan, or any other available benefit. This assignment shall remain in effect until revoked in writing.

**Consent to Medical Treatment:** I hereby request and give consent for the health care professionals at River Hills Community Health Center to provide medical treatment to me and/or my family.

**Consent to Dental Treatment:** I hereby request and give consent for the dental care professionals at River Hills Community Health Center to provide dental treatment to me and/or my family to include exam, radiographs, prophylaxis and application of fluoride.

**Consent to Release Protected Health Information:** I authorize River Hills Community Health Center to release medical information relating to the patient to health insurance companies, health plans or third party payors, or their authorized agents, for the purpose of determining benefits payable in connection with services provided.

X

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Continued on next page...

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Notice Of Privacy Practices Acknowledgement**

I understand that, under HIPAA laws, I have certain rights to privacy regarding my health information. I understand that this information can and will be used for: Treatment, Payment, and Healthcare Operations. I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand this does not include the release of records.

X

\_\_\_\_\_  
*Patient or Responsible Party Signature*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Date*

**HIPAA Approved Contacts**

I hereby give permission to River Hills Community Health Center to disclose health and/or billing information to the individuals identified below that are involved in my care or payment of care.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_