



Diversified Services - Exceptional Healthcare

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 _____

Continue on back →

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-\$14,580	<input type="checkbox"/> \$14,581-\$20,412	<input type="checkbox"/> \$20,413-\$25,272	<input type="checkbox"/> \$25,273-\$29,160	<input type="checkbox"/> \$29,161 +
2	<input type="checkbox"/> 0-\$19,720	<input type="checkbox"/> \$19,721-\$27,608	<input type="checkbox"/> \$27,609-\$34,181	<input type="checkbox"/> \$34,182-\$39,440	<input type="checkbox"/> \$39,441 +
3	<input type="checkbox"/> 0-\$24,860	<input type="checkbox"/> \$24,861-\$34,804	<input type="checkbox"/> \$34,805-\$43,091	<input type="checkbox"/> \$43,092-\$49,720	<input type="checkbox"/> \$49,721 +
4	<input type="checkbox"/> 0-\$30,000	<input type="checkbox"/> \$30,001-\$42,000	<input type="checkbox"/> \$42,001-\$52,000	<input type="checkbox"/> \$52,001-\$60,000	<input type="checkbox"/> \$60,001 +
5	<input type="checkbox"/> 0-\$35,140	<input type="checkbox"/> \$35,141-\$49,196	<input type="checkbox"/> \$49,197-\$60,909	<input type="checkbox"/> \$60,910-\$70,280	<input type="checkbox"/> \$70,281 +
6	<input type="checkbox"/> 0-\$40,280	<input type="checkbox"/> \$40,281-\$56,392	<input type="checkbox"/> \$56,393-\$69,819	<input type="checkbox"/> \$69,820-\$80,560	<input type="checkbox"/> \$80,561 +
7	<input type="checkbox"/> 0-\$45,420	<input type="checkbox"/> \$45,421-\$63,588	<input type="checkbox"/> \$63,589-\$78,728	<input type="checkbox"/> \$78,729-\$90,840	<input type="checkbox"/> \$90,841 +
8	<input type="checkbox"/> 0-\$50,560	<input type="checkbox"/> \$50,561-\$70,784	<input type="checkbox"/> \$70,785-\$87,637	<input type="checkbox"/> \$87,638-\$101,120	<input type="checkbox"/> \$101,121 +
9	<input type="checkbox"/> 0-\$55,700	<input type="checkbox"/> \$55,701-\$77,980	<input type="checkbox"/> \$77,981-\$96,547	<input type="checkbox"/> \$96,548-\$111,400	<input type="checkbox"/> \$111,401 +
10	<input type="checkbox"/> 0-\$60,840	<input type="checkbox"/> \$60,841-\$85,176	<input type="checkbox"/> \$85,177-\$105,456	<input type="checkbox"/> \$105,457-\$121,680	<input type="checkbox"/> \$121,681 +
11	<input type="checkbox"/> 0-\$65,980	<input type="checkbox"/> \$65,981-\$92,372	<input type="checkbox"/> \$92,373-\$114,365	<input type="checkbox"/> \$114,366-\$131,960	<input type="checkbox"/> \$131,961 +
12+	<input type="checkbox"/> 0-\$71,120	<input type="checkbox"/> \$71,121-\$99,568	<input type="checkbox"/> \$99,569-\$123,275	<input type="checkbox"/> \$123,276-\$142,240	<input type="checkbox"/> \$142,241+

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 # _____