CommuniCare HEALTH CENTERS

PATIENT REGISTRATION

Site : _____
Staff Initials: _____

Patient Information

Last Name	First Name	Middle Name	
Social Security Number	Age	Birth Date	
Mailing Address		Apt/Suite No.	
City	State	Zip	County
Phone # 1 □ Home □ Work □ Cell	Phone # 2 □ Home □ Work □ Cell	Email Address	
May we email you with appointment information/reminders? □ Yes □ No	May we text your cell with appointment information/reminders? □ Yes □ No		

Responsible Party Information (Any patient under 18 must have a responsible party)

I am:
□ Patient (if 18 years or older) □ Custodial Parent □ Guardian □ Foster Parent

Last Name	First Name	Middle Initial	Date of Birth	□ Mr. □ Mrs. □ Ms.
Street Address	City	State	Zip	
Social Security Number	Phone # 1 □ Home □ Work □ Cell	Phone # 2 □ Home □ Work □ Cell		

Emergency Contact

we would call this contact if you become very sick or need assistance while you are here or if we had important information about your health care and could not reach you.

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

As a Health Center that gets federal funding, we must collect the following information. All your answers are kept confidential

Marital Status
□ Single □ Separated
□ Married □ Widowed
□ Divorced □ Civil Union

Race
□ Native American / Alaskan □ Multi-Racial
□ White □ Asian □ Native Hawaiian
□ Black / African American □ Other Pacific Islander

Primary Language **if not English:**

Do you need Interpretive Services □ Yes □ No

Ethnicity / Ethnic Origin
□ Hispanic □ Non-Hispanic

Military Service (refers to patient)
Are you a Veteran? □ Yes □ No

Do you live in Public Housing
□ Yes □ No

Agriculture Employment (patient or parent if patient is a child)
Are you employed year round? □ Yes □ No
Do you move often to find work? □ Yes □ No
Retired Farm Worker? □ Yes □ No

If you would like to qualify for our discount program please fill out this information or indicate that you are over the Federal Poverty Limit:

Over the Limit ____ Not Over the Limit ____
Family Household Size: _____
Household Income: _____

How did you hear about us?
□ Hospital Referral □ Outreach Worker □ Website
□ Doctor / Dentist Referral □ Billboard □ Facebook
□ Radio □ Newspaper □ Other
□ Friend / Family □ Work

Housing
Where did you sleep last night?
□ in my house / apartment □ With a friend / relative
□ Shelter □ Car
□ Do not have a place

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Insurance Information	Secondary Insurance Information
□ I have Medical Insurance (see information below) □ I have Dental Insurance (see information below) □ I do not have Medical Insurance □ I would like to apply for the Sliding Fee Scale	□ I have Medical Insurance (see information below) □ I have Dental Insurance (see information below) □ I do not have Medical Insurance □ I would like to apply for the Sliding Fee Scale
Insurance Company Name:	Insurance Company Name:
Policy Holder's Name:	Policy Holder's Name:
Medical Policy Number:	Dental Policy Number:
Billing Address for Insurance:	Billing Address for Insurance:
Policy Holder's Social Security Number:	Policy Holder's Social Security Number:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth
Policy Holder's Employer:	Policy Holder's Employer:

RELEASE OF INFORMATION/ FINANCIAL RESPONSIBILITY

I hereby authorize CommuniCare Health Centers (CCHC) to release any medical or other information needed to process all insurance claims. I authorize payment of insurance benefit directly to CCHC. I agree that I am responsible for payments for services rendered, deductibles and coinsurance. I am aware that failure to pay may result in termination of the patient/clinic relationship. A photocopy of this authorization shall be considered as valid as the original. This authorization will remain in effect until revoked by me in writing.

Acknowledgment of Review of Notice Privacy Rights, Patient Rights & Responsibilities, and Speak Up for Infection Prevention

I have reviewed the CommuniCare Health Centers **Notice of Privacy Practices**, which explains how my medical and psychological information will be used and disclosed, the **Notice of Patient Rights & Responsibilities**, which outlines my rights as a patient of CommuniCare Health Centers and defines my expected responsibilities as a CCHC patient, and the Joint Commission Handout **Speak Up**, which explains things I can do to prevent infection. I understand that I am entitled to receive a copy of all/any of these documents. I understand the information stated in the documents and was given an opportunity to ask questions. **Initial ____**

Consent for Treatment

Completed by the patient or the patient's legally authorized representative / parent:

CommuniCare Health Centers (CCHC) provides services regardless of race, residence, religion, income, sex, age, national origin, color, sexual preference, or contraceptive preference. I consent to medical treatment, dental treatment, electronic prescription history and diagnostic evaluation for myself or for the patient for whom I am the parent or legally authorized representative.

In the event that a staff member has a serious exposure to my blood or body fluids. I consent to the anonymous testing of any blood samples that I have already provided for evidence of a blood-borne virus infection. I also acknowledge that test for certain communicable disease may be reportable to public health agencies as required by law.

I understand that CommuniCare Health Centers will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that I will have the opportunity to discuss with my CommuniCare provider the nature and purpose of recommended treatment or procedure(s), as well as alternative methods. I understand this consent is valid until revoked in writing, which I may do at any time.

Signature of Authorization

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Representative: _____

Relationship to Patient: _____ Date: _____