PATIENT REGISTRATION FORM

(Please Fill Form Out Completely)

Date _______/_______/_______

PATIENT INFORMATION

How did you hear about us? [ ] Radio [ ] Newspaper [ ] Friend or Family Member [ ] Social Media [ ] Already a Patient

Patient Name ____ Birth Date:____/_____/_______
Last First Middle Name

Home Address _________________________ City ________________ State _______ Zip ________

Home Phone ___________________Cell Phone __________________Social Security.______________________

Email Address:_____________________________________ [ ] None

Gender Identity: [ ] Female [ ] Male [ ] Transgender Female /Male-to-Female [ ] Transgender Male/Female-to-Male

Sexual Orientation [ ] Straight [ ] Lesbian or Gay [ ] Bisexual [ ] Something Else [ ] Don't know

Race (check all that apply) [ ] Black/African American [ ] Caucasian/White [ ] American Indian/Alaska Native
[ ] Asian [ ] Native Hawaiian [ ] Pacific Islander [ ] Refused to report

Citizenship:
[ ] US Citizen by birth [ ] Immigrant [ ] Naturalized Citizen [ ] Permanent Resident Alien [ ] Refugee [ ] Student Visa

Ethnicity (check one)
[ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Arabic [ ] Other_____________ [ ] Refused to Report

Marital Status (check one) [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Partnered

Served in the U.S. Armed Services? [ ] Yes [ ] No Primary Care Provider (PCP) ___________________________

HOUSEHOLD INFORMATION- Please Complete to help us comply with Community Health Center reporting requirements.

Do you own or rent your home? [ ] Own [ ] Rent [ ] Live with someone [ ] Homeless Shelter
[ ] Transient/ In-Between Homes [ ] Other ______________________________

Language (check one) [ ] English [ ] Spanish [ ] Other(s) ______________________________________

Communication Assistance Required: **Translator?**[ ] yes [ ] No **Sign language?**[ ] Yes [ ] No **Reading?**[ ] Yes [ ] No

Income (All sources) $ ☐ Weekly ☐ Monthly ☐ Yearly	**Household Size:**

Employer: ____ [ ] Retired (year)_______ [ ] Not Employed

Employer's Address: _________________________________ Phone: (_____)___________________

Pharmacy: ____ Phone: (_____)___________________

Patient Registration Form (Eff: 06/15/2016)
Hchnfiles/HCHNForms/Clinical Forms/C-0039

INSURANCE SUBSCRIBER INFORMATION

Primary Insurance Company: ____________________ Billing Address: ______________________________________

Phone (______) ____________ Group No.: ________________ Identification No. ______________________________

Subscriber's Name: ____________________________________ Date of Birth:______________ Co-pay:____________

Subscriber's Address (if different from above):____

Social Security No. __________/______/____________ Family Size ________________

Secondary Insurance Company: ______________________ Billing Address: ________________________________

Phone (______) ____________ Group No.: ________________ Identification No. ______________________________

Subscriber's Name: ____________________________________ Date of Birth:______________ Co-pay:____________

Subscriber's Address (if different from above):____

Social Security No. __________/______/____________ Family Size ________________

Would you like information about our discount program or are you covered by our discount program? (check one):
[ ] Yes [ ] No

EMERGENCY CONTACT PERSON

Name ____ Phone (_____) ____________________

Relationship to Patient:____________________________________ Do they know you are a patient? ☐ yes ☐ no

IF PATIENT IS A MINOR THE FOLLOWING MUST BE COMPLETED

Name __________________________________ [ ] Parent [ ] Guardian Social Security No. _________/____/_________

Address____Date of Birth ____________________________

Gender (check one) [ ] Female [ ] Male

Marital Status (check one) [ ] Single [ ] Married [ ] Divorced [ ] Widow(er)

Home Phone (___)______________Cell Phone (__)_____________Driver's License No. ______________________

Employer's Name ________________________________ Employer's Address ______________________________

FINANCIAL RESPONSIBILITY

By signing this form, I authorize the following:

- The release of medical or other information necessary to process insurance claims.
- Payment of medical benefits directly to Hamilton Community Health Network (HCHN) for services rendered.

I understand that I am financially responsible for the total charges for services rendered which include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to HCHN.

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PRINT PATIENT'S NAME

____ ____________________________

Signature of Patient, Parent, or Legal Guardian **Date**