2021 Registration Form

Acct#:________________________

Family Health Care
Patient Registration Form

Patient Information

Legal Last Name		Legal First Name	Preferred Name		
DOB (mm/dd/yyyy)	**SSN**	**Street Address**	**City**	**State**	**Zip Code**

Primary Phone Number	☐ Home ☐ Cell ☐ Work	Secondary Phone Number	☐ Home ☐ Cell ☐ Work	Email Address

Would you like Family Health Care to send you appointment reminders by text (Text messages may not be secure and standard messaging rates apply)? ☐Yes ☐No

Would you like to sign up for our Patient Portal to securely access your health information online? ☐Yes ☐No

As a Federally Qualified Health Center, Family Health Care is required to ask the following questions. The information you provide is confidential. Please check "Decline to Specify" if you do not wish to answer a specific question.

Birth Sex:
☐ Male
☐ Female

Gender Identity (If under 18yrs old, you can select "Decline to Specify"):
☐ Male ☐ Female ☐ Transgender (☐MTF ☐FTM)
☐ Decline to Specify ☐ Something else:_________

Sexual Orientation (If under 18yrs old, you can select "Uncertain" or "Decline to Specify"):
☐ Straight/Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Uncertain
☐ Decline to Specify ☐ Something else:_________________

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Life-partnered ☐Separated

Preferred Language:
☐ English ☐ Spanish
☐ Other:__________________

Race (check all that apply):
☐ Asian ☐ Black ☐ White ☐ American Indian or Alaska Native
☐ Pacific Islander ☐ Native Hawaiian ☐ Decline to Specify
☐ Other:____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Decline to Specify

Migrant or Seasonal Agricultural Worker:
☐**Yes**, Migrant Agricultural Worker (temporarily moves for work)
☐**Yes,** Seasonal/Lawn Care Agricultural Worker (works during season)
☐**No**, not a Migrant or Seasonal Worker

Military Veteran:
☐Yes ☐No

Homeless Status:
☐Not Homeless
☐Homeless

Preferred Pharmacy
☐ FHC Pharmacy
☐ Other: ___________________________________
Location:___________________________________

Emergency Contact (By identifying an individual below, you authorize Family Health Care to share your health information with this person)
Name:_________________________ Phone #:________________
Relation: ☐Spouse ☐Parent ☐Child ☐Other:_______________

Guarantor/Financially Responsible Party Information (If guarantor is same as patient, do not fill out the rest of this section)

Guarantor Full Name		Guarantor DOB (mm/dd/yyyy)	Guarantor SSN	
Relationship to Patient ☐ Spouse ☐Parent ☐Child ☐Employer ☐ Other:_________________________	**Street Address**	**City**	**State**	**Zip Code**

Guarantor Primary Phone Number	☐ Home ☐ Cell ☐ Work	Guarantor Secondary Phone Number	☐ Home ☐ Cell ☐ Work

Family Health Care

Treatment and Payment Authorization

You are responsible for your own bill. To help you with this, Family Health Care will submit charges to your insurance carrier.

- I transfer to Family Health Care the medical reimbursement benefit under my insurance policy. I approve the release of any medical information needed for these benefits. This will be valid until I give written notice to undo it. I understand that I am responsible for all charges whether or not they are covered by insurance.
- I approve treatment for my child or myself.

Patient/Guardian Signature____ Date______________________

Notice of Privacy Practices and Patient Rights and Responsibilities

Family Health Care's Notice of Privacy Practices and your Rights and Responsibilities as a patient are posted at the registration window. You may ask for copies of these forms at any time from Family Health Care staff.

I have been offered and made aware of the Notice of Privacy Practices and the Patient Rights and Responsibilities.

Patient/Guardian Signature____ Date______________________

If registration is completed by staff over the phone,

____
Family Health Care Staff Signature

____
Date permission received from patient