2022 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					
Insurance Information: □ Medicare □ Kansas Medicaid □ Other: _____ □ Secondary_____ □ Policy Number: _____ □ Group Number: _____					
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					
Do you live in Section 8 Housing/Public Housing □Yes □No					
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		

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Preferred Pharmacy □ FHC Pharmacy □ Other: _____ Location:_____		

Emergency Contact

Name:_____ Phone #:_____

Relation: □ Spouse □ Parent □ Child □ Other: _____

I give permission to share the following with my Emergency Contact:

( ) **All Information** ( ) Appointment Day/Time ( ) X-Rays ( ) Medical Records ( ) Financial Information

( ) Personal Identifying Information ( ) Insurance Information ( ) Other

Treatment and Payment Authorization

Guarantor/Financially Responsible Party Information for patients younger than 18 yrs.				
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			

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_____

Patient Acknowledgement of Interpreter Services

I acknowledge that all forms were completed by myself or my guardian through an interpretation service.

Patient/Guardian Signature_____ Date_____

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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*