Today's Date: Month / Day / Year

FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name	First Name	MI	Nickname	Birth Date	Social Security #

Patient's Primary Physician:

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (If different)	City	State	Zip

Which Contact # You Prefer:
☐ Home Phone# (____)_____
☐ Cell Phone # (____)_____
☐ Work Phone # (____)_____

EMAIL: _____

Can we send notifications?
☑ **All that Apply:**
☐ Opt Out
☐ Phone ☐ Text ☐Voicemail
☐eMessage

Consent to share data with external healthcare entities:
☐ Send
☐ Receive
☐ Opt Out

Birth Gender:
☐ Female
☐ Male

Gender Identity:
☐ Choose not to Disclose ☐ Other
☐ Female
☐ Female-to-Male (FTM) Transgender Male
☐ Genderqueer, neither exclusively Male or Female
☐ Male
☐ Male-to Female, (MTF) Transgender Female

Sexual Orientation:
☐ Choose not to Disclose
☐ Straight, Heterosexual
☐ Bisexual
☐ Lesbian, Gay, Homosexual
☐ Don't Know
☐ Other

Preferred Language:
☐English ☐ Spanish
☐Chinese ☐ Japanese
☐French ☐ Russian
☐Arabic
☐Other: _____

Marital Status:
☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Separated
☐ Life Partner

Race:
☐ White/Caucasian
☐ Black/African American
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ Other: _____

Ethnicity:
☐ Decline
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

INSURANCE INFORMATION (Please present ALL Insurance Cards and Picture ID to the receptionist):

Primary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Dental Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Vision Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship

ADVANCED DIRECTIVE:

Do you have a living will? ☐ Yes ☐ No Is it on file with your Primary Care Provider? ☐ Yes ☐ No

REQUIRED REPORTING

Living Arrangement:
☐ Alone
☐ Spouse only
☐Family
☐ Relative
☐ Roommate
☐ Institution

Family Size: _____

Living Situation:
☐ House/Apt
☐ Mobile Home
☐ Shelter
☐ Transitional
☐ Homeless/Street
☐ Public Housing
☐ Other: _____

Veteran:
☐ Yes
☐ No

Migrant:
☐ Yes
☐ No

Seasonal:
☐ Yes
☐ No

Family Income:
☐ < $10,000
☐ $10 - $20,000
☐ $20 - $40,000
☐ $40 - $60,000
☐ $60,000 <

☐ **Refuse to report**

Preferred Pharmacy:
_____

Family Health is required to report the following information annually. You do have the right to refuse to report.

☐ Kiosk Check-In

FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM

RESPONSIBLE PARTY:					
Last Name	First Name	MI	Social Security #	Birth Date	Relationship

Employer Name:	Employer Address:_____	Employer Phone: ( )

I understand that by signing this form, I agree to pay all balances pertaining to the services rendered. If I do not pay or should my account become delinquent, I realize that my information may be sent to a collection agency. I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, to communicate with me for any reason by any telephone number, email, and mailing address provided.

X_____ _____

Patient Name/Responsible Party (Print) **Signature of Patient/Responsible Party** **Date of Signature**

☐ Patient ☐Parent ☐Guardian

IF PATIENT IS UNDER 18 YEARS OLD:			
Parent/Guardian #1		Parent/Guardian #2	
First Name	Last Name	First Name	Last Name
Phone:		Phone:	

EMERGENCY CONTACT:			
Name	Relationship	DOB	Phone

Health Insurance Portability and Accountability (HIPAA)
Accountability for Release of Health Information/Notice of Privacy Practices

Authorization for Release of Health Information

I authorize that the following people may have access to my health information. I understand that the physician must have looked at and signed off the information before it will be copied and given to the authorized person(s) named below.

Name	Relationship	Phone ( )
Name	Relationship	Phone ( )
Name	Relationship	Phone ( )
Name	Relationship	Phone ( )

I wish to be contacted in the following manner (check all that apply):

☐Home Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Work Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number

☐Other: _____

Notice of Privacy Practices

Acknowledgment of Receipt Patient's Name (PRINTED)

Family Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, the patient.

I, the patient (or Patient Representative on behalf of the patient) acknowledge that I have seen or received a copy of the Family Health *Notice of Privacy Practices.*

_____ _____

Patient's Name (PRINTED) **Relationship to Patient**

X_____ _____

Patient Signature or Patient's Representative **Date**

[ ] Check here to opt out of receiving notifications regarding fund-raising efforts Family Health may undertake.