

**SALINA FAMILY HEALTHCARE CENTER
NEW PATIENT REGISTRATION FORM**

Chart #: _____

The following information helps us take better care of you. All information obtained is handled in a private and confidential manner. Any blank will be considered a “declined to comment.”

Legal Name: _____

Preferred Name: _____ Preferred Pronouns (he, she): _____

Legal Sex: M F
While SFHC recognizes a number of genders and sexes, many insurance companies and legal entities do not. Please be aware that the legal name and sex you have listed on your insurance must be used on all documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different from these, please let us know.

Date of Birth: / / Social Security #: - -

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone: Cell Phone: Work Phone: Best number to use:
() () () Home Cell Work

Street address: City: State: Zip:

Is this public housing? Yes No

Billing Address (if different than above): City: State: Zip:

Email Address: Preferred Method of contact:
 Phone Email Letter Text

Occupation: Employer/School Name:

Emergency Contact’s Name: Phone Number: Relationship to you:
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Parent/Guardian Name: Phone Number: Relationship to you:
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Primary Caregiver (if different than Parent/Guardian): Phone Number: Relationship to you:
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By law, if you are not the legal Parent/Guardian for a minor, we must have a Treatment Authorization for Minor form notarized and on file. (See front desk for form)

INSURANCE INFORMATION

Regardless of what services you are receiving at Salina Family Healthcare Center, please fill out the following information regarding your health insurance: **(Please give your insurance card to the receptionist.)**

Insurance Carrier Name: **ID#** **Group#**

The following information is for demographic purposes and will not affect your access to care or the quality of care you receive.

Race <input type="checkbox"/> White <input type="checkbox"/> Black/ African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other Pacific Islander	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Sign Language <input type="checkbox"/> Other (please specify) _____	Have you been homeless at any time in this calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Veteran <input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran		Are you a seasonal or migrant farmworker? <input type="checkbox"/> Yes <input type="checkbox"/> No SEE NEXT PAGE



Marital Status: <input type="checkbox"/> Unknown <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner	Do you think yourself as: <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know	What is your gender? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Other	Do you have an advance directive (living will or DNR)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give a copy to the front desk
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Household Size and Income (Under the number of people in your household, check the range of income that pertains to you):

<u>1 Person</u> <input type="checkbox"/> \$0 – 12,140 <input type="checkbox"/> \$12,141 – 18,210 <input type="checkbox"/> \$18,211 – 24,280 <input type="checkbox"/> Over \$24,281	<u>2 People</u> <input type="checkbox"/> \$0 - 16,460 <input type="checkbox"/> \$16,461 - 24,690 <input type="checkbox"/> \$24,691 - 32,920 <input type="checkbox"/> Over \$32,921	<u>3 People</u> <input type="checkbox"/> \$0 - 20,780 <input type="checkbox"/> \$20,781 – 31,170 <input type="checkbox"/> \$30,171 – 41,560 <input type="checkbox"/> Over \$41,561	<u>4 People</u> <input type="checkbox"/> \$0 – 25,000 <input type="checkbox"/> \$25,101 – 37,650 <input type="checkbox"/> \$37,651 – 50,200 <input type="checkbox"/> Over \$50,201
<u>5 People</u> <input type="checkbox"/> \$0 – 29,420 <input type="checkbox"/> \$29,421 – 44,130 <input type="checkbox"/> \$44,131 – 58,840 <input type="checkbox"/> Over \$58,841	<u>6 People</u> <input type="checkbox"/> \$0 – 33,740 <input type="checkbox"/> \$33,741 – 50,610 <input type="checkbox"/> \$50,611 – 67,480 <input type="checkbox"/> Over \$67,481	<u>7 People</u> <input type="checkbox"/> \$0 – 38,060 <input type="checkbox"/> \$38,060 – 57,090 <input type="checkbox"/> \$57,090 – 76,120 <input type="checkbox"/> Over \$76,121	<u>8 People</u> <input type="checkbox"/> \$0 – 42,380 <input type="checkbox"/> \$42,381 – 63,570 <input type="checkbox"/> \$63,571 – 84,760 <input type="checkbox"/> Over \$84,761

Please list by name and specialty, any healthcare providers you see outside of Salina Family Healthcare Center (ex: OB/GYN, GI, Cardiologist, Therapist, etc.):

Name of Doctor/Clinic	Type of Doctor/Clinic
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____

Permission to Release Health Information: List the names of family and/or friends we may release information about your healthcare to:

This consent shall remain in effect until a new list is provided or until revoked, in writing.

None

1) _____	Phone #: ()
2) _____	Phone #: ()
3) _____	Phone #: ()

Patient or Legal Guardian Signature: _____	Today's Date: _____
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For Office Use Only
Form Processed by: _____