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:	
Parent/Guardian Name:	Phone Number: ( )	Relationship to you:	
Primary Caregiver (if different than Parent/Guardian):	Phone Number: ( )	Relationship to you:	
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 ❑ White ❑ Black/ African American ❑ Asian ❑ Native Hawaiian ❑ American Indian/Alaskan Native ❑ Other Pacific Islander	**Ethnicity** ❑ Hispanic/Latino ❑ Not Hispanic/Latino **Veteran** ❑ Veteran ❑ Not a Veteran	**Preferred Language** ❑ English ❑ Spanish ❑ Vietnamese ❑ Sign Language ❑ Other (please specify) _____	**Have you been homeless at any time in this calendar year?** ❑ Yes ❑ No **Are you a seasonal or migrant farmworker?** ❑ Yes ❑ No

SEE NEXT PAGE

Marital Status:	**Do you think yourself as:**	**What is your gender?**	**Do you have an advance directive (living will or DNR)?**
❑ Unknown ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner	❑ Straight (not lesbian or gay) ❑ Lesbian or gay ❑ Bisexual ❑ Something else ❑ Don't know	❑ Male ❑ Female ❑ Transgender Male/Female-to-Male ❑ Transgender Female/Male-to-Female ❑ Other	❑ Yes ❑ No **If yes, please give a copy to the front desk**

Household Size and Income (Under the number of people in your household, check the range of income that pertains to you):

1 Person	**2 People**	**3 People**	**4 People**
❑ $0 – 12,060	❑ $0 - 16,240	❑ $0 - 20,420	❑ $0 - 24,600
❑ $12,061 – 18,090	❑ $16,241 - 24,360	❑ $20,421 - 30,630	❑ $24,601 - 36,900
❑ $18,091 – 24,120	❑ $24,361 - 32,480	❑ $30,631 - 40,840	❑ $36,901 - 49,200
❑ Over $24,121	❑ Over $32,481	❑ Over $40,841	❑ Over $49,201
5 People	**6 People**	**7 People**	**8 People**
❑ $0 - 28,780	❑ $0 - 32,960	❑ $0 - 37,140	❑ $0 – 41,320
❑ $28,781 - 43,170	❑ $32,961 - 49,440	❑ $37,141 - 55,710	❑ $41,321 - 61,980
❑ $43,171 - 57,560	❑ $49,441 - 65,920	❑ $55,711 - 74,280	❑ $61,981 - 82,640
❑ Over $57,561	❑ Over $65,921	❑ Over $74,281	❑ Over $82,641

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/Legal Guardian Signature:	**Today's Date:**

For Office Use Only

Form Processed by: _____