

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

**Information helps us care for you and is handled in a private and confidential manner. Blanks considered "declines comment".**

Legal Name:			
Preferred Name:			
Legal Sex: M F		Assigned Sex at Birth (if different): M F	
SFHC recognizes a number of genders and sexes. Many insurance companies and legal entities do not. The legal name and sex on your insurance must be used on all insurance, billing, and corresponding documents. Let us know your preferred name and pronouns.			
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:	

**PERMISSION TO RELEASE INFORMATION: List people we may release information about your healthcare to. (New list is required each time form is completed. Consent remains in effect until new list is provided or revoked in writing.)**

Emergency Contact No one else		
1)	Phone #:( )	
2)	Phone #:( )	
3)	Phone #:( )	
Legal Parent/Guardian #1 Name:	Phone #:	Relationship:
Legal Parent/Guardian #2 Name:	Phone #:	Relationship:
Primary Caregiver (if not Parent/Guardian):	Phone #:	Relationship:

Notarized Treatment Authorization for Minor form REQUIRED if you are not Legal Parent/Guardian. See front desk for form.

**INSURANCE INFORMATION**

**Fill out ALL the following information regarding your health insurance. (GIVE YOUR INSURANCE CARDS TO RECEPTIONIST.)**

Primary Medical Insurance Name:	ID#	Group#
Secondary Medical Insurance Name:	ID#	Group#
Primary Dental Insurance Name:	ID#	Group#
Secondary Dental Insurance Name:	ID#	Group#
Vision Insurance 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.

<b>Race</b> White Black/African American Asian Native Hawaiian American Indian/Alaskan Native Pacific Islander Other	<b>Ethnicity</b> Hispanic/Latino Not Hispanic/Latino	<b>Preferred Language</b> English Spanish Vietnamese Sign Language Other (please specify) _____
	<b>Veteran</b> Veteran Not a Veteran	

<b>Marital Status</b> Unknown (U) Married (M) Single (S) Divorced (D) Separated (X) Widowed (W) Partner (P)	<b>Sexual Orientation</b> Straight or heterosexual Lesbian, gay or homosexual Bisexual Something else, please describe: Don't know Choose not to disclose	<b>Preferred Pronouns</b> He/him She/her They/them	<b>Gender identity</b> Male Female Transgender Male Female-to-Male Transgender Female Male-to-Female Gender non-conforming (neither exclusively male nor female) Additional gender category/other, please specify Choose not to disclose
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Have you been homeless at any time in this calendar year?      Yes      No

Are you a seasonal or migrant farmworker?      Yes      No

Do you have an advance directive (living will or DNR)?      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):**

<b>1 Person</b> \$ 0 - \$ 14,580 \$ 14,581 - \$ 19,537 \$ 19,538 - \$ 24,349 \$ 24,350 - \$ 29,160 Over \$ 29,161	<b>2 People</b> \$ 0 - \$ 19,720 \$ 19,721 - \$ 26,425 \$ 26,426 - \$ 32,932 \$ 32,933 - \$ 39,440 Over \$ 39,441	<b>3 People</b> \$ 0 - \$ 24,860 \$ 24,861 - \$ 33,312 \$ 33,313 - \$ 41,516 \$ 41,517 - \$ 49,720 Over \$ 49,721	<b>4 People</b> \$ 0 - \$ 30,000 \$ 30,001 - \$ 40,200 \$ 40,201 - \$ 50,100 \$ 50,101 - \$ 60,000 Over \$ 60,001
<b>5 People</b> \$ 0 - \$ 35,140 \$ 35,141 - \$ 47,088 \$ 47,089 - \$ 58,684 \$ 58,685 - \$ 70,280 Over \$ 70,281	<b>6 People</b> \$ 0 - \$ 40,280 \$ 40,281 - \$ 53,975 \$ 53,976 - \$ 67,268 \$ 67,269 - \$ 80,560 Over \$ 80,561	<b>7 People</b> \$ 0 - \$ 45,420 \$ 45,421 - \$ 60,863 \$ 60,864 - \$ 75,851 \$ 75,852 - \$ 90,840 Over \$ 90,841	<b>8 People</b> \$ 0 - \$ 50,560 \$ 50,561 - \$ 67,750 \$ 67,751 - \$ 84,435 \$ 84,436 - \$ 101,120 Over \$ 101,121

**Please list name and specialty of 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)
4)	4)

**Patient/Legal Guardian Signature:**

**Today's Date:**

For Office Use Only  
Form Processed by: \_\_\_\_\_