Chart #_____

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.

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

Marital Status	**Sexual Orientation**	**Preferred Pronouns**	**Gender identity**
☐ Unknown (U) ☐ Married (M) ☐ Single (S) ☐ Divorced (D) ☐ Separated (X) ☐ Widowed (W) ☐ Partner (P)	☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Something else, please describe: ☐ Don't know ☐ Choose not to disclose	☐ He/him ☐ She/her ☐ They/them	☐ 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

Have you been homeless at any time in this calender 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):

1 Person	**2 People**	**3 People**	**4 People**
☐ $ 0 - $ 15,060	☐ $ 0 - $ 20,440	☐ $ 0 - $ 25,820	☐ $ 0 - $ 31,200
☐ $ 15,061 - $ 20,180	☐ $ 20,441 - $ 27,390	☐ $ 25,821 - $ 34,599	☐ $ 31,201 - $ 41,808
☐ $ 20,181 - $ 25,150	☐ $ 27,391 - $ 34,135	☐ $ 34,600 - $ 43,119	☐ $ 41,809 - $ 52,104
☐ $ 25,151 - $ 30,120	☐ $ 34,136 - $ 40,880	☐ $ 43,120- $ 51,640	☐ $ 52,105 - $ 62,400
☐ Over $ 30,121	☐ Over $ 40,881	☐ Over $ 51,641	☐ Over $ 62,401

5 People	**6 People**	**7 People**	**8 People**
☐ $ 0 - $ 36,580	☐ $ 0 - $ 41,960	☐ $ 0 - $ 47,340	☐ $ 0 - $ 52,720
☐ $ 36,581 - $ 49,017	☐ $ 41,961 - $ 56,226	☐ $ 47,341 - $ 63,436	☐ $ 52,721 - $ 70,645
☐ $ 49,018 - $ 61,089	☐ $ 56,227 - $ 70,073	☐ $ 63,437 - $ 79,058	☐ $ 70,646 - $ 88,042
☐ $ 61,090 - $ 73,160	☐ $ 70,074 - $ 83,920	☐ $ 79,059- $ 94,680	☐ $ 88,043 - $ 105,440
☐ Over $ 73,161	☐ Over $ 83,921	☐ Over $ 94,681	☐ Over $ 105,441

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:_____