

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: First Name: Middle Initial: Last Name:

Preferred Name:

Legal Sex: M F

The legal name and sex on your insurance must be used on all insurance, billing, and corresponding documents.

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

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

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):

1 Person \$ 0 - \$ 15,650 \$ 15,651 - \$ 20,971 \$ 20,972 - \$ 26,136 \$ 26,137 - \$ 31,300 Over \$ 31,301	2 People \$ 0 - \$ 21,150 \$ 21,151 - \$ 28,341 \$ 28,342 - \$ 35,321 \$ 35,322 - \$ 42,300 Over \$ 42,301	3 People \$ 0 - \$ 26,650 \$ 26,651 - \$35,711 \$ 35,712 - \$ 44,506 \$ 44,507 - \$ 53,300 Over \$ 53,301	4 People \$ 0 - \$ 32,150 \$ 32,151 - \$43,081 \$ 43,082 - \$53,691 \$ 53,692 - \$64,300 Over \$ 64,301
5 People \$ 0 - \$ 37,650 \$ 37,651 - \$ 50,451 \$ 50,452 - \$ 62,876 \$ 62,877 - \$ 75,300 Over \$ 75,301	6 People \$ 0 - \$ 43,150 \$ 43,151 - \$ 57,821 \$ 57,822 - \$ 72,061 \$ 72,062 - \$ 86,300 Over \$ 86,301	7 People \$ 0 - \$ 48,650 \$ 48,651 - \$ 65,191 \$ 65,192 - \$ 81,246 \$ 81,247 - \$ 97,300 Over \$ 97,301	8 People \$ 0 - \$ 54,150 \$ 54,151 - \$ 72,561 \$ 72,562 - \$ 90,431 \$ 90,432 - \$ 108,300 Over \$ 108,301

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: _____