PATIENT REGISTRATION FORM

Patient Information

Social security #: ____________ D.O.B. ____________ Email: ____________

(Name) First: ____________ M.I. _____ Last: ____________

Address: ____________

City: ____________ State: _____ Zip: ____________

(Phones) Home: ____________ Cell: ____________ Work: ____________

# of family members in household: ________ Employer: ____________ Gross Income: ____________ Are you a veteran? Yes No

Marital status:	Single	Married	Divorced	Widowed			
Sexual Orientation (circle):	Straight	Lesbian or Gay	Bisexual	Something else	Don't Know		Choose not to disclose
Gender:	Male	Female	Transgender/Male-to-Female		Transgender/Female-to-male	Other	Choose not to disclose
' Preferred Language:	English	Spanish	Korean	Other	Ethnicity:	Hispanic	Non-Hispanic
Race:	Black / African American	White	Native Hawaiian	Other Pacific Islander	Amer. Indian /Alaska Native	Asian	More than one race
Employment Status:	Full-Time	Part-Time	Self-Employed		Non-Employed	Retired	Active Military

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How did you find out about JHC? (circle): Prior Experience with Johnson Health Center

Referral (from Free Clinic, Social Services, ect) Outreach Event (health event, craft fair) Television

Word of Mouth (friend, family) Internet (facebook, website) Newspaper (article, advertisement)

Guarantor/Responsible Party Information (If different than patient information above)

Full name: ____________

Address: ____________

City: ____________ State: ______ Zip: ____________

Relationship to guarantor: ____________

(Phones) Home: ____________ Cell: ____________ Work: ____________

Social security number: ____________ D.O.B. ____________

Primary Medical Insurance Information

Insurance: ____________ Name of insured: ____________

Insured's D.O.B.: ____________ Relationship to patient: ____________

Group number: ____________ Policy number: ____________ Effective date: ____________

Secondary Medical Insurance Information

Insurance: ______________________ Name of insured: ______________________

Insured's D.O.B.: ______________________ Relationship to patient: ______________________

Group number: ____________ Policy number: ____________ Effective date: ____________

Spouse or Emergency Contact Information

Full name: ____

Address: ____

City: ________________ State: ______ Zip: ______________

(Phones) Home: ____________ Cell: ________________ Work: ________________

AUTHORIZATION FOR TREATMENT

_________ *Initials*

_________ *Date*

I consent for Johnson Health Center's appropriate personnel and/or clinical staff to perform acute, chronic, and/or emergency medical treatment and preventative, health maintenance, and/or behavioral/mental health care as deemed medically necessary. (If the named individual on other side of this page is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment). A "Behavioral Health Consultant" is a member of the primary care team that works closely with your medical provider to recognize and address medical conditions associated with acute and chronic mental and emotional disordered conditions. There is only one electronic health record used between primary care team members in addressing your treatment plan of care and this health information is shared between these primary care team members.

AUTHORIZATION FOR PAYMENT

_________ *Initials*

_________ *Date*

I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize Johnson Health Center to file my insurance for services rendered. I request that payment be made directly to Johnson Health Center. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that claims may be filed electronically through a safety net Internet portal. I understand that I am responsible for any and all balances that my insurance company does not pay.

AUTHORIZATION TO LEAVE MESSAGES

_________ *Initials*

_________ *Date*

If we are unable to contact you and you have an answering machine or voicemail, do we have your permission to leave a message containing medical information (circle appropriate): **YES NO**

If yes, where may we leave messages (circle appropriate): **HOME CELL WORK**

NOTICE OF PRIVACY PRACTICES

_________ *Initials*

_________ *Date*

I have received and read the Notice of Privacy Practices from Johnson Health Center.

PATIENT RIGHTS &RESPONSIBILITIES

_________ *Initials*

_________ *Date*

I have received a copy of the Patient Rights & Responsibilities and had an opportunity to ask question regarding them.

MEDICATION POLICY

_________ *Initials*

_________ *Date*

I understand that Johnson Health Center will access the Virginia Prescription Monitoring Program to verify medication use and to avoid medication interactions.

______________________________________ Date: ________________

Patient Signature (Parent/Guardian if minor)

(This consent form will be used as needed and you may revoke or change any of the above consents at any time)