



**Patient Registration Form**

**Patient Information**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Identify person filling out form:  Self/patient  Parent/guardian (name) \_\_\_\_\_  
Please list other parent/guardian, if applicable: \_\_\_\_\_

**Contact Information** *(if patient is a minor, use parent/legal guardian contact info)*

Email: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Guarantor/Responsible Party Information** *(if different from patient information above)*

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Medical Insurance Information**

**Primary Medical Insurance Information**

Insurance: \_\_\_\_\_ Name of policy holder: \_\_\_\_\_  
Policy holder's DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_ Effective date: \_\_\_\_\_

**Secondary Medical Insurance Information**

Insurance: \_\_\_\_\_ Name of policy holder: \_\_\_\_\_  
Policy holder's DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_ Effective date: \_\_\_\_\_

**Emergency Contact Information**

Full name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Staff Use:** Data entered into EMR by \_\_\_\_\_ Date \_\_\_\_\_

## Demographic Information

Check answers below with patient information, not parent/legal guardian info, if patient is a minor.

### Marital Status:

- Single     Married     Divorced     Widowed

### Sexual Orientation:

- Straight     Lesbian/Gay     Bisexual  
 Something else     Don't know     Choose not to disclose

### Gender:

- Male (M)     Transgender, M-to-F     Other  
 Female (F)     Transgender, F-to-M     Choose not to disclose

### Preferred Language:

- English     Spanish     Korean     Other

### Ethnicity:

- Hispanic     Non-Hispanic

### Race (select all that apply):

- Black/African American     White     Native Hawaiian     Other  
 Native American/Native Alaskan     Asian     Other Pacific Islander    \_\_\_\_\_

### Employment Status:

- Full-time     Part-time     Self-employed     Non-employed     Retired     Active Military

### Insurance:

- Private Insurance     Do not have insurance     Do not have prescription coverage  
 Medicaid     Medicare/Medicaid QMB

Are you a veteran?     Yes     No

Are you experiencing homelessness?     Yes     No

If yes, where are you staying?

- Street     Transitional housing     Unknown  
 Doubling up     Homeless shelter     Other

Are you a seasonal or migrant worker?     Yes     No

If yes, how many people in your family are with you? \_\_\_\_\_

Household size, including yourself: \_\_\_\_\_

Household income: \$ \_\_\_\_\_     Choose not to disclose

## How did you find out about JHC? (check)

- Prior experience with Johnson Health Center     Community event (health event, craft fair, etc.)  
 Referral (from Free Clinic, Social Services, etc.)     Print ad (newspaper, article, advertisement)  
 Word of mouth (friend, family)     Television  
 Internet (Facebook, website)

Staff Use: Data entered into EMR by \_\_\_\_\_ Date \_\_\_\_\_

## Patient Authorizations and Notifications

*This consent form will be used as needed, and you may revoke or change any of the above consents at any time. Please initial beside each statement. Sign and date at the bottom of the page.*

### **Authorization for Treatment**

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.

Initial: \_\_\_\_\_

### **Authorization for Payment**

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.

Initial: \_\_\_\_\_

### **Authorization to Leave Messages**

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**

Initial: \_\_\_\_\_

### **Notice of Privacy Practices**

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

Initial: \_\_\_\_\_

### **Patient Rights & Responsibilities**

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

Initial: \_\_\_\_\_

### **Medication Policy**

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

Initial: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature *(parent/legal guardian if minor)*

\_\_\_\_\_  
Date

**This Page for Office Use Only**

**Page 1**

*Patient Information*

Comments: \_\_\_\_\_

*Guarantor/Responsible Party*

Comments: \_\_\_\_\_

*Primary Medical Insurance Information*

Comments: \_\_\_\_\_

*Secondary Medical Insurance Information*

Comments: \_\_\_\_\_

*Emergency Contact*

Comments: \_\_\_\_\_

**Page 2**

*Members of the Household*

Comments: \_\_\_\_\_

*Household Income*

Comments: \_\_\_\_\_

**Page 3**

*Authorization for Treatment*

Patient Declined

*Authorization for Payment*

Patient Declined

*The patient made aware that declination means that they will receive a bill for all services provided?*

Yes       No

*Authorization to Leave Messages*

Patient Declined

*Notice of Privacy Practices*

Patient Declined

*Patient Rights & Responsibilities*

Patient Declined

*Medication Policy*

Patient Declined