JOHNSON HEALTH CENTER

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
☐ Referral (from Free Clinic, Social Services, etc.)
☐ Word of mouth (friend, family)
☐ Internet (Facebook, website)
☐ Community event (health event, craft fair, etc.)
☐ Print ad (newspaper, article, advertisement)
☐ Television

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