Patient Registration Form

Patient Information

First Name: ____________________ MI: ______ Last Name: ____________________

Address: ______________________________ DOB: ____________________

City: ____________________ State: ______________ Zip Code: ____________________

Preferred Pharmacy: ____

Identify person filling out form: ☐ Self/Patient ☐ Parent/Guardian (name) ____________________

Please list other parent/guardian if applicable: ____

Are there custody arrangements in place? ☐ Yes ☐ No

If yes, please provide the office with a copy of the custody paperwork.

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

Email: ____

Phone Number (circle one): ______________________________ Cell phone Home 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 Code: ____________________

Email: ____

Phone Number (circle one): ______________________________ Cell phone Home phone Work phone

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: ______________

Dental Insurance Information

Insurance: ____________________ Name of Policy Holder: ____________________

Policy Holder's DOB: ____________________ Relationship to Patient: ____________________

Group Number: ______________ Policy Number: ______________ Effective Date: ______________

Staff Use: Data entered into EMR by: ______________________________ Date: ______________

Emergency Contact Information

Full Name: ______________________ Relationship to Patient: ______________________

Address: ____

City: ________________ State: ____________ Zip Code: ________________

Email: ____

Phone Number (circle one): ____________________ Cell phone Home phone Work phone

Demographic Information

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

Sex Assigned at Birth: ▯ Male ▯ Female ▯ Unknown ***Marital Status:*** ▯ Single ▯ Married ▯ Divorced ▯ Widowed

Sexual Orientation: ▯ Straight ▯ Lesbian/Gay ▯ Bisexual ▯ Other ▯ Don't Know ▯ Choose not to disclose

Gender Identity: ▯ Male(M) ▯ Female(F) ▯ Transmasculine ▯ Transfeminine ▯ Other ▯ Choose not to disclose

Preferred Language: ▯ English ▯ Spanish ▯ Korean ▯ Other ***Are you a Veteran?*** ▯ Yes ▯ No

Employment Status: ▯ Full-time ▯ Part-time ▯ Self-employed ▯ Non-employed ▯ Retired ▯ Active Military

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

Ethnicity: ▯ Hispanic ▯ Non-Hispanic

If Hispanic, then one of the following should be selected: ▯ Mexican ▯ Mexican American ▯ Chicano ▯ Puerto Rican ▯ Cuban ▯ Another Hispanic/Latino/a or Spanish origin ▯ Choose not to disclose

Race (select all that apply): ▯ Black/African American ▯ White ▯ Native Hawaiian ▯ Chinese ▯ Filipino ▯ More than one race ▯ Japanese ▯ Korean ▯ Native American/Native Alaskan ▯ Asian Indian ▯ Vietnamese ▯ Other Asian ▯ Guamanian ▯ Chamarro ▯ Samoan ▯ Other Pacific Islander ▯ Choose not to disclose

Are you experience homelessness? ▯ Yes ▯ No ***If yes, where are you staying?*** ▯ Street ▯ Transitional Housing ▯ Doubling up ▯ Homeless Shelter ▯ Unknown ▯ 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

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This Page for Office Use Only

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

▯ Yes ▯ No

Is registration complete?

▯ Yes ▯ No

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

Staff Use: Data entered into EMR by: ______________________________ Date: ______________