# PATIENT REGISTRATION FORM

**Patient Information**

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| Last Name | | First Name | | | **Middle Name** | | | |
| **SSN** | | **Date of Birth** | | | **Gender: Male Female** | | | |
| Address | | **City**   **State** | | | | | **Zip Code** | |
| **Will you Need Interpreter Services?**    **YES**  **NO** | **Language Spoken**  **English**  **Spanish**  **Other**\_\_\_\_\_\_\_\_ | | | **How well do you speak English (Five - 5 years old or older)?**  **Very well Well**  **Not well Not at all** | | | | |
| **Mother’s Maiden Name \*used only for identification purposes.** | | | | | | | | |
| **Marital Status**  **Single Married Widowed Divorced**    **Student Status**  **Are you currently in School? No Yes**  **If yes, Full Time Part Time** | | | **Home Phone (**  ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Cell Phone (** ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Work Phone** ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Can confidential messages be left on your telephone answering machine?**  **YES**  **NO** | | | **Homeless?**  **Yes–what type**  **No**  **Doubling-up**  **Shelter**  **Street**  **Other**  **Transitional** | | |
| **Race**  **Asian**  **Native Hawaiian**  **Other Pacific Islander**  **Black / African-American**  **White**  **American Indian / Alaska Native**  **More than one Race**  **Do not wish to report** | | | **Ethnicity: Are you Hispanic, Latino/a, or Spanish origin?**  **Yes No**  **Decline to provide** | | | | | |
| **Employment Status***:*  **Full-time**  **Part-time**  **Self-Employed**  **Retired**  **Unemployed**  **Disabled**  **Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Highest grade completed \_\_\_\_\_\_\_\_\_**  **N/A**  **Less than high school**  **High school diploma**  **Some college**  **College graduate**  **Post graduate** | | | | | **Referred by:**  **\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_** |
| **INSURANCE INFORMATION (please present all insurance information upon arrival to the clinic)**  ***PRIMARY INSURANCE COMPANY:*** ***Effective Date:*** *\_\_\_/\_\_\_/\_\_\_*    **TennCare / Medicaid Medicare Other (Employer/Private/Commercial) No insurance**    **Policy Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Plan Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Insured’s relationship to patient: Self Spouse Parent Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (specify)**  **Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |

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| ***SECONDARY OR DENTAL INSURANCE COMPANY:***    **TennCare / Medicaid Medicare Other (Employer/Private/Commercial) No insurance**  **Policy Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Plan Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Insured’s relationship to patient: Self Spouse Parent Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (specify)**  **Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **RESPONSIBLE PARTY INFORMATION**  **Who is responsible for this bill? (if different than patient information)**  **Self – Other – please complete section below**   Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_ **SSN \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female**    **Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Home Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Employer(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **INCOME INFORMATION**  **Total Household Income last month:** *$\_\_\_\_\_\_\_\_\_\_*  **Decline to provide household income**  **Total Persons living in household last month: \_\_\_\_\_\_**   |  | | --- | | **OFFICE USE ONLY :** | | **Qualify for sliding fee discounts? No Yes - 100% & below 101-133% 134-175% 176-200%**  **Unknown** |   **Medical Insurance**: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.  **The person signing for themselves or on behalf of the Patient as the responsible party must:**   1. **Present all current insurance cards prior to each office visit.** 2. **Inform the Health Center of the current address and phone # for the patient and responsible party.** 3. **Pay any required copay at the time of the visit.** 4. **Pay any additional amount owing within 30 days of receiving a statement from our office.**   **FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR TREATMENT**:  I affirm that the information that I am providing is true and correct. I understand that if I provide false or inaccurate information that services may be discontinued and I will have to pay for all services received according to the fee schedule.  I authorize any medical treatment, anesthetics or surgical procedures, as the provider deems necessary.  I hereby authorize my provider to release medical information as required and permitted by law.  Should this account become delinquent and be referred to any attorney or collection agency for Collection, the undersigned will pay actual attorney’s fees and Collection expenses.  A $40.00 fee is charged on all returned checks.  In addition to cash or check, Visa and MasterCard are accepted.  ***By signing below, I agree to the above mentioned statement.***  **Patient’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **EMERGENCY CONTACT: Person to contact in case of emergency:**  **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # (\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_** |