PRIORITY HEALTH CARE
A UNIVERSAL APPROACH TO CARE

# PATIENT REGISTRATION FORM

**PATIENT INFORMATION**

| **Last Name:** | **First Name:** | **M.I.:** | **Previous Name (if applicable)** |
|---|---|---|---|
| **Mailing Address:** | | **Apt #** | |
| **City/State/Zip:** | | | **Parish:** |
| **Home Phone:** | **Cell Phone:** | | **Work Phone:** |

Calling/Contact Instructions (Check all that apply): ☐ Okay to leave a message ☐ Don't leave a message ☐ Other ______________________

**Email Address:** | Would you like access to the patient portal? Please consent: ☐ Yes ☐ No

Consented Method of Contact (Check all that apply): ☐ Phone ☐ Mail ☐ Email ☐ Text

| **Social Security #:** _____/______/_______ | | **Date of Birth:** _____/_____/______ |
|---|---|---|
| **Emergency Contact Name:** | **Emergency Contact #:** | **Relationship to Patient:** |

**Preferred Pharmacy Name & Location:**

**FOR MINORS ONLY (if patient is under 18 years old):**

| **Parent/Legal Guardian of Minor:** | **Date of Birth:** _____/_____/______ | **Address:** | **Relationship to Minor:** |
|---|---|---|---|

**SOCIO-ECONOMIC INFORMATION**

**NOTE:** As a Federally Qualified Health Center, Priority Health Care (PHC) is required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists PHC in applying for additional grant funds to support and expand its services. Thank you for your cooperation.

| | |
|---|---|
| **Marital Status:** | ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other ☐ Legally Separated ☐ Other ______________________ |
| **Gender:** | ☐ Male ☐ Female ☐ Transgender Man/Transgender Male/Transmasculine ☐ Transgender Woman/Transgender Female/Transfeminine<br>☐ Unknown ☐ Other ______________________ |
| **Sexual Orientation:** | ☐ Heterosexual or Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't Know ☐ Unknown ☐ Choose Not to Disclose<br>☐ Other ______________________ |
| **Race:** | ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander<br>☐ Samoan ☐ Guamanian or Chamorro ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ More Than One Race<br>☐ Unreported/Choose Not To Disclose Race |
| **Ethnicity:** | ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino, or Spanish Origin<br>☐ Hispanic, Latino Spanish Origin, Combined ☐ Not Hispanic, Latino, or Spanish Origin ☐ Unreported/Choose Not to Disclose Ethnicity |
| **Preferred Language:** | ☐ English ☐ Spanish ☐ Chinese ☐ Sign Language ☐ Unreported/refused to report<br>☐ Other ______________________<br>**Veteran:** ☐ Yes ☐ No ☐ Unknown |
| **Agricultural Status:** | ☐ Migrant Worker ☐ Seasonal Worker ☐ Dependent of Migrant Worker ☐ Dependent of Seasonal Worker ☐ Not Agricultural Worker |
| **Referral Source (How did you hear about PHC?):** | ☐ Doctor's Office ☐ Insurance Company ☐ Billboard ☐ Bus Shelter Sign ☐ Radio ☐ Bus Sign ☐ Family/Friend ☐ Newspaper ☐ Website<br>☐ Other ___________________ |
| **Adults Housing Status:** | ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Public Housing ☐ Not Homeless ☐ Permanent<br>☐ Other ______________________ |
| **Pediatrics Housing Status:** | ☐ Living with Parents ☐ Living with Relatives ☐ Living with Step Family ☐ Living with Grandparent(s) ☐ Living in A Foster Home<br>☐ Living In A Juvenile Group Home(ward of the State) ☐ Living In A Homeless Shelter ☐ Other living situations ___________________ |

**HEAD OF HOUSEHOLD INFORMATION:**

| **Last Name:** | **First Name:** | **M.I.:** | **Previous Name (if applicable)** |
|---|---|---|---|
| **Home Phone:** | **Cell Phone:** | **Work Phone:** | **How many people live in your home?** |

| **Annual Household Income:** | | | |
|---|---|---|---|
| | ☐ $0-$14,580 | ☐ $14,581-$18,300 | ☐ $18,301-$23,000 |
| | ☐ $23,001-$27,700 | ☐ $27,701-$32,400 | ☐ $32,401-$37,100 |
| | ☐ $37,101-$41,900 | ☐ $41,901-$46,000 | ☐ Over $46,000 |

INSURANCE INFORMATION

## PERSON RESPONSIBLE FOR BILL (ONLY IF DIFFERENT FROM PATIENT)

| Last Name: | First Name: | M.I.: | Previous Name (if applicable) |
|---|---|---|---|
| Mailing Address: | | Apt # | |
| City/State/Zip: | | Parish: | Email Address: |
| Home Phone: | Cell Phone: | | Work Phone: |

| ☐ I HAVE NO INSURANCE. | PRIMARY MEDICAL INSURANCE | | SECONDARY MEDICAL INSURANCE | |
|---|---|---|---|---|
| Your household income and family size may qualify you and your family for Priority Health Care's Sliding Fee Discount Program.<br><br>Our Patient Services Specialists can assist you with any questions and help you apply.<br><br>Priority Health Care also offers payment plans and hardship waivers. | Insurance Company Name: | | Insurance Company Name: | |
| | Policy Holder Name: | | Policy Holder Name: | |
| | Policy Holder's Date of Birth: | | Policy Holder's Date of Birth: | |
| | Policy Holder's Social Security #: | | Policy Holder's Social Security #: | |
| | Member ID: | | Member ID: | |
| | Patient Relationship to Policy Holder: | | Patient Relationship to Policy Holder: | |
| | Patient Relationship to Policy Holder: | | Patient Relationship to Policy Holder: | |

ACKNOWLEDGEMENTS

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand Priority Health Care's (PHC) Summary Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that PHC may update its' Summary Notice of Privacy Practices at any time and that I may receive an updated copy by submitting a request in writing.

## PATIENT ATTESTATION

I declare, under penalty of perjury, that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services. I hereby acknowledge that I am applying for assistance under a U.S. HRSA funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.

| Patient or Legal Guardian Signature: | Date |
|---|---|
| | |