PATIENT REGISTRATION

Today's Date: _____/_____/_____

Patient Information
Please Print

Patient Last Name	First Name	Middle Initial	Preferred Name	Date of Birth

Home Address	City	State	Zip	Birth Gender: ☐ M ☐ F Gender Identity: ☐ M ☐ F ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Other ☐ Choose not to disclose

Home Phone #	Cell Phone #	Preferred Contact Method *(check all that apply)*
		☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email ☐ Other

Email Address: *(print below or check the option that applies)*	Social Security Number	Sexual Orientation:
☐ Do Not Have ☐ Other ☐ Choose Not to Disclose		☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Don't know ☐ Other ☐ Choose not to disclose

Employer Name and Address	Work Phone #

Emergency Contact Name	Emergency Phone #	Relationship to Patient

Primary Care Physician Name and Phone #	Pharmacy Name and Phone #

MARITAL STATUS:
☐ Single ☐ Married ☐ Widow
☐ Partner ☐ Divorced ☐ Legally Separated
☐ Unknown ☐ Decline to Specify

LANGUAGE:
☐ English
☐ Spanish
☐ Other _____

RACE: (SELECT ALL THAT APPLY)
☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black/African American
☐ White ☐ Hawaiian Native ☐ Pacific Islander ☐ Decline to Specify
☐ Other _____

ETHNICITY:
☐ Hispanic/Latino ☐ Non-Hispanic/Latino
☐ Decline to Specify

EMPLOYMENT STATUS:
☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ On Active Military Duty
☐ Unemployed ☐ Retired ☐ Full-Time student ☐ Part-Time Student

VETERAN:
☐ Yes
☐ No

HOUSING STATUS:
☐ Own/Rent ☐ No Permanent Housing *(homeless)*
** If No Permanent Housing, where are you currently staying?
☐ Street ☐ Doubling up ☐ Transitional ☐ Shelter ☐ Other

TRANSPORTATION STATUS:
Do you have reliable transportation? ☐ Yes ☐ No
** Have you used public transportation in the last 6 months?
☐ OATS ☐ WILS ☐ Other ☐ None

HAVE BEEN TO ER OR ADMITTED TO HOSPITAL SINCE LAST VISIT
☐ Yes ☐ No
** If Yes, were you referred to us from the ER?
☐ Yes ☐ No ER Name: _____

CONTACT REGARDING MEDICAL COVERAGE?
☐ Yes ☐ No

CURRENT ADVANCED DIRECTIVE?
☐ Yes ☐ No

SEASONAL WORKER:
☐ Yes ☐ No

MIGRANT WORKER:
☐ Yes ☐ No

LIMITED ENGLISH PROFICIENCY?
☐ Yes ☐ No

CONSENT TO EXCHANGE RECORDS WITH YOUR OTHER HEALTHCARE PROVIDERS FOR CONTINUITY OF CARE:
☐ Send & Receive ☐ Send Only ☐ Receive Only ☐ Choose to Opt Out

WHAT IS YOUR ANNUAL HOUSEHOLD INCOME?
_____

HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD?
_____

The above information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of the Live Well Community Health Centers (LWCHC – all locations). You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will be released except in aggregate form.

PATIENT REGISTRATION

Person Responsible for Payment
(if different than patient)

Last Name	First Name	Middle Initial	Relationship to Patient

Mailing Address	City	State	Zip

Home Phone #	Cell Phone #	Date of Birth	Social Security Number

Employer Name	Employer Address	Work Phone #

Primary Medical Insurance

Name of Insurance Company	Policy ID or Member #	Group #	Effective Date

Insurance Claims Address *(Street, City, State, Zip)*	Insurance Phone #

Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth	Relationship to Patient

Employer Name	Employer Address	Work Phone #

Primary Dental Insurance

Name of Insurance Company	Policy ID or Member #	Group #	Effective Date

Insurance Claims Address *(Street, City, State, Zip)*	Insurance Phone #

Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth	Relationship to Patient

Employer Name	Employer Address	Work Phone #

Secondary Insurance
☐ Medical ☐ Dental

Name of Insurance Company	Policy ID or Member #	Group #	Effective Date

Insurance Claims Address *(Street, City, State, Zip)*	Insurance Phone #

Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth	Relationship to Patient

Employer Name	Employer Address	Work Phone #

Facility Responsible for Patient Care (if different than patient)			
Facility Name			Business Phone #
Mailing Address	City	State	Zip

The following authorizations are to be completed and initialed by a parent, legal guardian or person representing legal custody to the child, prior to appointment with our providers.

The policy of LWCHC, in all needed medical, dental or behavioral health requiring hospitalization, is to secure in advance the proper authorizations from parent(s), guardian or legal custodian.

Legal Guardian Information (if different than patient)			
Last Name	First Name	Middle Initial	Relationship to Patient
Mailing Address	City	State	Zip
Home Phone #	Cell Phone #	Date of Birth	Social Security Number
Employer Name	Employer Address		Work Phone #

Legal Guardian Information (if different than patient)			
Last Name	First Name	Middle Initial	Relationship to Patient
Mailing Address	City	State	Zip
Home Phone #	Cell Phone #	Date of Birth	Social Security Number
Employer Name	Employer Address		Work Phone #

☐ **Guardianship paperwork given to HCC/LWCHC when applicable**

ASSIGNMENT OF INSURANCE:

I hereby authorize payment directly to HCC/Live Well Community Health Centers for the medical, dental and/or behavioral health benefits for any services furnished to me or my dependents. I hereby authorize HCC/LWCHC to release any information acquired in the course of my examination or treatment necessary to establish a health insurance claim payment. I understand that occasionally my insurance company will deny payment for services that my physician and/or I feel necessary for my good health. Please note that self-pay/sliding scale patients may incur additional charges outside of self-pay office visit fees. I agree to pay for such services in a prompt and timely manner. I hereby authorize HCC/LWCHC providers to prescribe treatment, administer medications, and perform such procedures and tests that may be deemed advisable or necessary in the diagnosis of me or my dependents. _____ Initials

RELEASE OF MEDICAL INFORMATION:

I authorize HCC/LWCHC to release information to the following listed below: _____ Initials

Name	Phone Number	Relation	Emergency Contact	HIPAA
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

AUTHORIZATION FOR SHARED MEDICAL RECORD CONSENT WITHIN HCC/LWCHC:

I understand that my medical, dental and behavioral health records, will be shared by the above stated entities when medically necessary, on a need to know basis. _____ Initials

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge that HCC/LWCHC has made available to me the HIPAA notice of privacy practices. _____ Initials

AUTHORIZATION TO PROVIDE MEDICAL & HEALTH CARE SERVICES:

I hereby authorize HCC/LWCHC to provide medical examination services, immunological services, and routine medical/health services as considered normal and necessary; to secure and consent to medical, surgical, dental, and psychiatric care that is deemed necessary by a licensed physician, nurse, or mental health provider. _____ Initials

APPOINTMENT POLICY:

HCC/LWCHC requires at least 24-hour notice from patients who need to cancel or reschedule an appointment. A patient is considered a No Show, if they are 15 minutes late for their scheduled appointment. It is at the discretion of the Clinic Manager or the Provider whether the patient will be rescheduled or if they can be worked into the schedule.

As a patient of the clinic, you and your family agree to:

1. Arrive early or on time to all scheduled appointments
2. Keep the clinic informed of changes to your contact information.
3. Agree that if you No Show for 3 visits within 6 months that you will be placed on a restricted status of, walk-in or same-day appointments only.
4. If you do not show up for an appointment, you will have a No-Show appointment. If you do not give at least 24-hour notice to cancel or reschedule an appointment or you are asked to reschedule due to late arrival, you will have a broken appointment.
5. Due to the high demand for late afternoon appointments, if a member of your family has a Broken or No-Show appointment during these times, you may no longer be able to schedule late afternoon appointments for your family. _____ Initials

IF I AM UNABLE TO BRING MY CHILD(REN) TO AN APPOINTMENT, I GIVE PERMISSION FOR _____TO BRING THEM.

PATIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY NAME (*please print*): _____

☐ **I would like to apply for the Discount Slide Fee Program. By checking this box you agree to complete an additional Slide Fee Application.**