Greene County Health

PATIENT REGISTRATION FORM

Verified By:
DATE REC/ENTERED: ____/____/____
STAFF INITIALS: _____

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in **Black or Blue Pen Only***

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____
Do You Need Interpreter Services? ☐ YES ☐ NO

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION
Family/Household Size: _____
Household Income: $ _____
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Choose not to disclose

GENDER
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE
☐ TRANSGENDER FEMALE
☐ OTHER
☐ DO NOT WISH TO REPORT

SEXUAL ORIENTATION
☐ LESBIAN OR GAY
☐ STRAIGHT/HETEROSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ DO NOT WISH TO REPORT

GENDER AT BIRTH
☐ MALE
☐ FEMALE

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO
If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

As a Health Center we are required to collect this information. All answers are confidential.

EMERGENCY CONTACT

NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

Primary Insurance

☐ **I currently have MEDICAL insurance (see below)**
☐ **I currently DO NOT have MEDICAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: _____

Policy/ID Number: _____

Insured/Policy Holder's Information

Name: _____

Relationship to Patient:_____

Date of Birth _____ Social Security # _____

Seconday Insurance

☐ **I currently have Secondary MEDICAL insurance (see below)**
☐ **I currently DO NOT have Seconday MEDICAL insurance**

Medical Insurance Name: _____

Policy/ID Number: _____

Insured/Policy Holder's Information

Name: _____

Relationship to Patient:_____

Date of Birth _____ Social Security # _____

Greene County Health

PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

PRINT PATIENT'S FULL NAME: _____

PATIENT'S DATE OF BIRTH: _____ **TELEPHONE:** _____

PATIENT'S ADDRESS: _____

_____

I give Greene County Health permission to discuss protected health information and to release test results to the following person(s):

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

_____

I give Greene County Health permission to leave any protected health information on an answering machine or voicemail. ____Yes ___ No Telephone Number:_____

By signing this form, I give Greene County Health permission to send your medical information to the address provided.

Indicate your relationship to the patient: _____Patient _____Patient Representative

_____

Print Name (if you are not the patient)

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRSENTATIVE **TODAY'S DATE**

This form is good for 1 year unless you tell us otherwise. If you want to, choose another date:

_____

Greene County Health

ADULT CONSENT & ACKNOWLEDGMENT FOR SERVICES

Name: _____

Completion of this consent is necessary to offer services to a patient. Some items may not apply to your current situation; however, in order to provide comprehensive care during this visit and future visits we request that you complete this consent in its entirety. You have the privilege of revoking this consent, by providing written notice, at any time.

CONSENT FOR TESTING AND TREATMENT

By initialing below, I authorize the health care providers at Greene County Health (GCH), to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. I understand I may ask my health care providers about my care, treatment and procedures at any time and I am encouraged to do so.

_____ (Initials)

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

By initialing below, I understand and acknowledge that Greene County Health is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of the Practice such as improving care and treatment services.

_____(Initials)

ASSIGNMENT OF BENEFITS

By initialing below, I hereby assign to Greene County Health any and all payments to which I am entitled under Medicaid, Medicare and/or third party insurer for health care or behavioral services rendered to me by Greene County Health. I further authorize Greene County Health to bill and receive payment directly from Medicaid, Medicare or my insurance carrier(s) for those services that Greene County Health delivered and for which I may be entitled to insurance coverage. I also authorize Greene County Health to give Medicaid, Medicare and/or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving primary health care or behavioral health services

_____ (Initials)

FINANCIAL RESPONSIBILITY

By initialing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from Greene County Health. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and co-payments.

_____ (Initials)

TERMS OF CONSENT

By signing below, I agree to the terms and information above. I am giving this consent of my own free will.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

Patient Name Printed	Initials
Signature of Patient or Parent / Guardian or Power of Attorney	Date
Witness Signature	Date