Today's Date: Month / Day / Year

FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM

FAMILY Health
BUILDING HEALTHY LIVES TOGETHER

PATIENT INFORMATION:

Last Name	First Name	MI	Preferred Name	Birth Date	Social Security #

Patient's Primary Physician:

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (If different)	**City**	**State**	**Zip**

Which Contact # You Prefer:
☐ Home Phone# (____)_____
☐ Cell Phone # (____)_____
☐ Work Phone # (____)_____
EMAIL:
_____

Can we send notifications?
☑ **All that Apply:**
☐ Opt-Out
☐ Phone ☐ Text
☐Voicemail ☐e-Message

Consent to share data with external healthcare entities:
☐ Opt-In
☐ Opt-Out
☐ Emergency

Birth Gender:
☐ Female
☐ Male

Marital Status:
☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Separated☐ Life Partner

Preferred Language:
☐English ☐ Spanish
☐Chinese ☐ Japanese
☐French ☐ Russian
☐Arabic
☐Other: _____

Gender Identity:
☐ Female
☐ Male
☐ Female-to-Male (FTM) Transgender Male
☐ Male-to Female, (MTF) Transgender Female
☐ Neither exclusively Male or Female (Genderqueer)
☐ Choose not to Disclose ☐ Other

Sexual Orientation:
☐ Straight, Heterosexual
☐ Bisexual
☐ Lesbian, Gay, Homosexual
☐ Don't Know
☐ Choose not to Disclose
☐ Other

Pronouns:
☐he/him/his/himself
☐she/her/hers/herself
☐they/them/their/theirs/themselves
☐Other: _____

Race:
☐ White/Caucasian
☐ Black/African American
☐ American Indian/Alaska Native
☐ Asian ☐ Asian Indian
☐ More than one race
☐ Chinese ☐ Hawaiian/Pacific Islander
☐ Japanese ☐ Native Hawaiian
☐ Korean ☐ Other Pacific Islander
☐ Filipino ☐ Samoan
☐ Vietnamese
☐ Other:_____

Ethnicity:
☐ Non-Hispanic or Latino/Or Spanish Origin
☐ Hispanic or Latino/Spanish Origin
☐Mexican/Mexican American/Chicano
☐Cuban ☐Puerto Rican
☐ Decline

INSURANCE INFORMATION (Please present ALL Insurance Cards and Picture ID to the receptionist):

Primary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Dental Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Vision Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship

ADVANCED DIRECTIVE:

Do you have a living will? ☐ Yes ☐ No Is it on file with your Primary Care Provider? ☐ Yes ☐ No

REQUIRED REPORTING

Permanent Housing:
☐ House/Apt/Mobile Home

Family Size: _____

Temporary/Transitional Housing:
☐ Shelter
☐ Homeless/Street
☐ Transitional
☐ Temporarily Living with Friends/Family
☐ Permanently Living with Friends/Family
☐ Other: _____

Veteran:
☐ Yes ☐ No

Migrant Agriculture Worker:
☐ Yes ☐ No

Seasonal Agriculture Worker: (NON OH/IN Residents)
☐ Yes ☐ No

Family Income:
☐ < $10,000
☐ $10 - $20,000
☐ $20 - $40,000
☐ $40 - $60,000
☐ $60,000 <

☐ **Refuse to report**

Preferred Pharmacy:
_____

Family Health is required to report the following information annually. You do have the right to refuse to report.

Revised 07/25/24

☐ Kiosk Check-In

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RESPONSIBLE PARTY:					
Last Name	First Name	MI	Social Security #	Birth Date	Relationship
Employer Name:	Employer Address:_____		Employer Phone: ( )		

I understand that by signing this form, I agree to pay all balances pertaining to the services rendered. If I do not pay or should my account become delinquent, I realize that my information may be sent to a collection agency. I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, to communicate with me for any reason by any telephone number, email, and mailing address provided.

X_____ _____

Patient Name/Responsible Party (Print) **Signature of Patient/Responsible Party** **Date of Signature**

☐ Patient ☐Parent ☐Guardian

IF PATIENT IS UNDER 18 YEARS OLD:			
Is there custody involvement? ☐ Yes ☐ No *If yes please see front desk for Acknowledgement of Child Custody Matters			
Parent/Guardian #1		Parent/Guardian #2	
First Name	Last Name	First Name	Last Name
Phone:		Phone:	

EMERGENCY CONTACT:			
Name	Relationship	DOB	Phone

Health Insurance Portability and Accountability (HIPAA)
Accountability for Release of Health Information/Notice of Privacy Practices

Authorization for Release of Health Information

I authorize that the following people may have access to my health information. I understand that the physician must have looked at and signed off the information before it will be copied and given to the authorized person(s) named below.

Name	Relationship	Phone ( )
Name	Relationship	Phone ( )
Name	Relationship	Phone ( )
Name	Relationship	Phone ( )

I wish to be contacted in the following manner (check all that apply):

☐Home Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Work Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number

☐Other: _____

Notice of Privacy Practices

Acknowledgment of Receipt Patient's Name (PRINTED)

Family Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, the patient.

I, the patient (or Patient Representative on behalf of the patient) acknowledge that I have seen or received a copy of the Family Health *Notice of Privacy Practices.*

_____ _____

Patient's Name (PRINTED) **Relationship to Patient**

X_____ _____

Patient Signature or Patient's Representative **Date**

[ ] Check here to opt out of receiving notifications regarding fund-raising efforts Family Health may undertake.