HEART OF FLORIDA HEALTH CENTER

Health Care Application

*must be updated annually

PATIENT INFORMATION

Last Name	First Name	MI	DOB (MM/DD/YY)	SS#

Street Address	City	State	Zip	County

Is Patient Insured?
Medical: □ Yes Dental: □ No
□ Yes □ No

If Patient under 18:

Mother's/Guardian Name ______________________________
Date of Birth: _____ /_____/______

Father's/Guardian Name ______________________________
Date of Birth: _____ /_____/______

CONTACT INFORMATION

Primary Phone Number □ **Home** □ **Cell**

Secondary Phone Number □ **Home** □ **Cell**

HFHC may contact me for clinical/appointment reminders by the following methods: (check all that apply)

□ **Text message** (Standard data/messaging rates may apply) □ **Email:**______________________________

Emergency Contact: __________________________ *Relationship:* ___________ *Phone #:* _________________

Please confirm if you have an Advance Directive: □ Yes □No

(legal document that goes into effect if you are incapacitated or unable to speak for yourself- states your values and desires related to end-of-life care)

PATIENT DEMOGRAPHICS

Primary Language Spoken
□ English □ Spanish
□ Other:______________________________

Would you like an interpreter?
□ Yes □No

Race (Check all that apply)
□ Asian □ Black □ White
□ Central American Indian
□ American Indian/Native Alaskan
□ Pacific Islander □ Native Hawaiian
□ Other: ____________
□ Declined to Specify

Ethnicity
□ Hispanic/Latino
□ Non-Hispanic/Latino
□ Refused to report

Gender Identity:
Do you think of yourself as:
□ Male
□ Female
□ Transgender (□ Male-to-Female □ Female-to-Male)
□ Other, please specify:
□ Prefer not to disclose

Sexual Orientation:
Do you think of yourself as?
□ Straight or heterosexual
□ Lesbian, gay, or homosexual
□ Bisexual
□ Prefer not to disclose
□ Something else ____________

Marital Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Partner

Student
□ Full-Time
□ Part- Time
□ Not a student

Employment Status
□ Full-Time
□ PartTime
□ Un-Employed
□ Retired

Employer **Zip Code**

Migratory or Seasonal Agricultural Worker?
□ Yes □ No

Military Veteran?
□ Yes □ No

How Did You Hear About the Health Center? Circle One

Family Friend Flyer Hospital Local Organization Health Fair Internet Other:_____________

PREFERRED PHARMACY: ____ **(include address)**

***If not completed HFHC will default this section to our internal pharmacy.**

INSURANCE

Primary Medical Insurance: ____
Subscriber Number: ____
Policy Holders Name: ___________________________ □Self □Parent □Spouse
Policy Holders Date of Birth: _____ /_______/__________

Secondary Medical Insurance: ___________________________________
Subscriber Number: ____
Policy Holders Name: ________________________ □Self □Parent □Spouse
Policy Holders Date of Birth: _____ /_______/__________

Patient/Parent/Legal Guardian Signature: _______________________________________ Date: ______________

All patients are requested to read, initial, and comply with Heart of Florida Health Center's (HFHC) below. If you have any questions about our policies, please ask to speak with our front desk personnel.

Notice of Patient Privacy Practices

I understand that as a patient of Heart of Florida Health Center, all information collected will be kept confidential under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I acknowledge that I have received the Notice of Privacy Practices from Heart of Florida Health Center.

Patients Initials Here: ________

Appointment and Financial Responsibility

We request that all new patients arrive 30 minutes prior to your appointment to register. All payments are expected at time of service. Alert a staff member of any changes in your information to make sure we have the most updated information in your account. Make sure you provide proper identification, required documentations, and insurance cards (if any) at the time of the visit. Minors must always be accompanied by an adult.

Patients Initials Here: _________

Primary Care Physician Assignment

Patients who are covered by certain managed care health plans need to assign Heart of Florida health Center as their Primary Care Physician at the time of their appointment. Patient may coordinate with insurance plan for re-assignment and be seen with a confirmation number provided by the insurance company. If re-assignment is not completed in 30 days patient will be billed for the full fee of their office visit. Most importantly no referrals nor prior authorizations can be processed until assignment is completed.

Patients Initials Here: ________