# Patient Registration Form

**Section 1**

As a Federally Qualified Health Center, we are required to collect demographic information regarding the

 Patients we serve. The information you provide is confidential. Please check “Choose not to disclose” if you do not wish to answer a specific question.

|  |
| --- |
| **Patient Information** |
| **Last Name:** | **First Name:** | **Middle Name:** | **DOB**  **/ /** |
| **Ad dress:** | **Social Security #** | **Sex Assigned at Birth:*** Male **☐** Female
 |
| **City:** | **State:** | **Zip Co de:** |
| **Main Phone:** | **Cell Phone:** | **Email:** |
| OK to Text? **☐** Yes **☐** No |
| **Marital Status:*** Single **☐** Married **☐** Divorced **☐** Partner **☐** Widowed **☐** Legally Separated **☐** Choose not to disclose
 |
|  **Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Do you need an interpreter?** **☐** Yes **☐** NoHearing Impaired or need sign language interpreter services? **☐** Yes **☐** No |
| **Race: *Check all that apply**** Asian **☐** Native Hawaiian **☐** Other Pacific Islander
* African American / Black **☐** American Indian or Alaska Native **☐** Caucasian/White
* Choose not to disclose
 |
| **Ethnicity: ☐** non-Hispanic **☐** Hispanic **☐** Choose not to disclose |
| **US Veteran ☐** YES **☐** NO **Migratory agricultural ☐** YES **☐** NO **Seasonal agricultural ☐** YES **☐** NO |
| **Living Arrangements:*** Permanent Residence (own, rent apartment /room / house) **☐** Transitional Housing (center, community, home)
* Shelter (safe haven, temporary overnight housing) **☐** Permanent Supportive Housing
* Doubling up (living with other people for a temporary period) **☐** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Sexual Orientation:*** Lesbian or Gay **☐** Straight **☐** Bisexual
* Something else **☐** Don’ t know **☐** Chose not to disclose
 |
| **Gender Identity:*** Male **☐** Transgender Male (Female to Male) **☐** Other:
* Female **☐** Transgender Female (Male to Female) **☐** Chose not to disclose
 |
| **Do you have an ADVANCE DIRECTIVE? ☐** Yes **☐** No |
| **Emergency Contact** |
| Name: | Phone: |
| Relationship: **☐** Parent **☐** Guardian **☐** Spouse **☐** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Preferred Pharmacy** |
| **Pharmacy Name and address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\*If not completed HFHC will default this section to our pharmacy.** |
| **Acknowledgement of Information** |
| PRINT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**  DATE: Relationship: **☐** Self **☐** Parent/ Legal Guardian |

# Insurance Information

**Section 2**

|  |
| --- |
| **Please provide identification and insurance cards at the time of registration.** |
| **Do you have: Any Medical Insurance: ☐** Yes **☐** No, **IF NO SKIP TO SECTION 3** |
| MEDICAL INSURANCE |
| Primary Insurance  | Insured (Name on the Insurance Card) | **Relationship to patient:****☐** Self **☐** Spouse/Partner**☐** Parent/ Guardian **☐** Other |
| Employer | Insured ’s Date of Birth | **Group Number** |
| Secondary Insurance  |  Insured (Name on the insurance Card) | **Relationship to patient:****☐** Self **☐** Spouse/Partner**☐** Parent/ Guardian **☐** Other |
| Employer | Insured ’s Date of Birth | **Group Number** |
| DENTAL INSURANCE |
| Dental Insurance  | Insured (Name on the insurance Card) | **Relationship to patient:****☐** Self **☐** Spouse/Partner**☐** Parent/ Guardian **☐** Other |
| Employer | Insured ’s Date of Birth | **Group Number** |
| **Is it OK to bill your insurance? ☐** Yes **☐** No *If no, please explain why?* (If we do not bill for services, you will be responsible to pay the full fee associated with your visit). |

# Sliding Fee Application & Self Declaration of Income

**Section 3**

Heart of Florida Health Center is a Non-Profit Organization that receives a defined amount of federal funding to supplement the cost of providing Medical/Dental care to patients who are eligible to participate in the sliding fee scale program. Eligible patients will also qualify for **reduced cost prescriptions or any uncovered service**. To determine your eligibility for this federally funded program, **verification of your income is required.** You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept confidential.

|  |  |
| --- | --- |
| **Income Information: You must provide us with proof of income to determine the sliding fee scale level.** |  |
| * **I decline the Sliding Fee Scale Discount Program.**
 |
| * I have no Income **☐** I am unemployed **☐** I am homeless **☐** I am self-employed
 | **Office Use Only**Sliding Fee Scale: \_\_\_\_Staff Initials:\_\_\_\_\_\_\_\_ |
| **What is your household income before taxes?***Household income includes your income and the income of all the members living in the home. This may include Wages, Tips, Salaries, Unemployment Benefits, Social Security and Disability Benefits, Retirement and Pension Benefits, Alimony or Child Support received, rental income or other income from a business.* |  **$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **☐ Monthly ☐ Yearly** |
| **What is your household Size?***A Household constitutes any group of individuals, with or without children, living under the same roof that pool resources for monthly expenses. Persons may or may not be related. Children if Full Time Students over 18 may be used if still claiming on annual income taxes.* | **\_\_\_\_\_\_\_# of adults****\_\_\_\_\_\_\_# of children** |
| **I have answered all questions truthfully, completely and to the best of my ability, including dollar amounts. I understand that failure to do so may result in denial of eligibility to receive services.** **I understand that I must provide copies of my paystubs or other documents as proof of income. *If unable to obtain copies of any of the above this document is to be used as proof of the above income.* The facility, its employees, officers, and practitioners are hereby released from any legal responsibility or liability for disclosures as indicated and authorized herein.**PRINT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**  DATE: Relationship: **☐** Self **☐** Parent/ Legal Guardian |  |

#  Consent for Treatment and Services

**Section 4**

**Medical Consent for Treatment**: I authorize HFHC and its medical, dental, nursing, and other health care staff to provide health care services and administer diagnostic and therapeutic procedures and treatments deemed necessary or advisable in the judgment of HFHC medical, dental or clinical personnel. This includes all routine medical and dental screening and diagnostic tests and procedures, including administration and/or injection of pharmaceutical products and medications, the withdrawal of blood for laboratory examination, radiology, behavioral health services, and case management, unless specifically declined. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed. I understand that I have the right to refuse consent to any proposed care, treatment, testing, surgery, or procedure. After evaluation, if my medical condition is beyond the capacity of HFHC services, I will be referred elsewhere for further care. Please specify any services to which you decline consent:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized persons to disclose personal health information. I understand that I have the right to revoke this authorization at any time. I understand the revocation will not apply to information that has already been released in response to this authorization. . I further understand that authorizing the release of my health information is voluntary. I can refuse to designate anyone in order to assure treatment. I understand that I may inspect or request a copy of information to be released as provided in C.F.R. 164.524. I understand any release of information carries with it the potential for re-release by the recipient and once authorized to be released, the information may not be protected by the federal confidentiality rules.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Name Relationship

**Consent for Use and Disclosure of Protected Health Information**: I authorize HFHC to use and disclose my health/prescription information to provide for, arrange or coordinate my health care treatment, enable HFHC to obtain payment for the services it provides to me; and permit HFHC to carry out ordinary health care and business operations. The information I authorize to release may include infectious or contagious disease information, including HIV or AIDS-related information, diagnosis, or treatment information; information about drug or alcohol abuse or treatment, and/or psychiatric or psychological information, as permitted by law. I understand that HFHC is required by law to report certain infectious diseases to public health agencies. I understand that HFHC is required by law to report suspected abuse or neglect of children or vulnerable adults to the appropriate state agency. For a more detailed description of uses and disclosures of protected health information, please review the Notice of Privacy Practices.

**Notice of Privacy Practices:** I acknowledge that a copy of the “NOTICE OF PRIVACY PRACTICES” has been made available to me.

**Patients’ Rights and Responsibilities**: I acknowledge that my healthcare is a partnership between HFHC Clinics and me; hence, I agree to actively participate and accept both my role and responsibility about my healthcare and the rights available to me. I have received the Patient Rights and Responsibilities notice.

**Responsibility for Payment & Assignment of Benefits**: I assign to HFHC all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by HFHC. I agree, that, except as may be limited by law or HFHC’S agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at HFHC facilities in accordance with the rates and terms of HFHC in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance, or deductibles. I understand that payment in full is expected on a timely basis.

I hereby certify that I have read or have had the foregoing information explained, that a copy has been made available to me, and that I am the patient or am duly authorized to execute the above and accept its terms. This consent is valid for one year from date signed unless otherwise specified. I understand that I may revoke this consent at any time by providing written notice to HFHC. Revocation will not affect any action taken in reliance on this authorization prior to receiving written notice of revocation

PRINT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DATE:

Relationship: **☐** Self **☐** Parent/ Legal Guardian

#  ****Dental/Medical History****

**Section 5**

**\*To be updated every 6 months**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Patient’s Name** |  | **Date of Birth** |

In the following questions, circle **Yes or No**, whichever applies. Your answers will be considered confidential

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rheumatic Fever or Heart Murmur  | Yes | No | AIDS/HIV Positive  | Yes | No |
| Substance Abuse (alcohol, inhalants, drugs) | Yes | No | **Blood Transfusions**  | Yes | No |
| Heart Trouble or Shortness of Breath | Yes | No | **Cancer**  | Yes | No |
| Tuberculosis (TB) Persistent Cough  | Yes | No | **Allergies or Skin Rash**  | Yes | No |
| Pacemaker/Artificial Heart Valves  | Yes | No | **Currently pregnant**  | Yes | No |
| Diabetes or Excessive Thirst  | Yes | No | **Asthma**  | Yes | No |
| High or Low Blood Pressure  | Yes | No | **Pregnant if yes, what trimester:**  | Yes | No |
| Epilepsy or Seizures  | Yes | No | **Thyroid Problems**  | Yes | No |
| Fainting or Dizzy Spells  | Yes | No | **Painful or Swollen Joints**  | Yes | No |
| Kidney Problems or Excessive Urination  | Yes | No | **Emotional Problems**  | Yes | No |
| Stroke  | Yes | No | **Taking Bisphosphonates (bone hardener)**  | Yes | No |
| Organ transplant or Immunosuppression  | Yes | No | **Neurological Problems**  | Yes | No |
| Anemia or Blood Problems  | Yes | No | **Developmental delays** | Yes | No |
| Liver Problems or Hepatitis  | Yes | No | **ADHD** | Yes | No |
| Sickle Cell Anemia  | Yes | No | **Autism** | Yes | No |
| Sexually Transmitted Disease  | Yes | No | **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| Excessive Bleeding or Bruise Easily  | Yes | No |  **­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |

1. Do you **(PATIENT)** have or have you **(PATIENT)** had any of the following
2. Are you **(PATIENT)** currently under the care of a physician (doctor)? **Yes No**

If yes, list name of doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you **(PATIENT)** been hospitalized in the last 2 years? **Yes No**

If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you **(PATIENT)** currently taking any medications, pills or drugs? **Yes No**

If yes, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you **(PATIENT)** allergic to or have you ever experienced any ill effect from a local anesthetic (Novocain), penicillin any drugs/pills? i.e., rash, itching or fainting. **Yes No**

If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you **(PATIENT)** ever experienced any unfavorable reaction from previous dental treatment? **Yes No**

If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you **(PATIENT)** currently having any dental pain or problem? **Yes No**

If yes, describe.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that | have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. | will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I also understand that before treatment is provided, | have the right to have the benefits, alternatives, and Significant risk factors associated with this treatment explained to my satisfaction.

PRINT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**  DATE:

Relationship: **☐** Self **☐** Parent/ Legal Guardian