Patient Registration Form

Section 1: Patient Demographics

Last Name: _____
First Name: _____
Middle Name: _____

Date of Birth: (MM/DD/YYYY): ____/____/_____
Sex: ☐ Male ☐ Female
Social Security #: _____

For Minors (18 years or less)

Parent/Guardian Full Name: _____
Relationship: _____
Date of Birth (MM/DD/YYYY): ____/____/_____

Parent/Guardian Full Name: _____
Relationship: _____
Date of Birth (MM/DD/YYYY): ____/____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other: _____

Address:
Street Address: _____
City: _____
State: _____
Zip Code: _____

Contact Information:
Home Phone: (____) _____
Cell Phone: (____) _____
Email: _____

Emergency Contact: Full Name: _____ Contact #: (____) _____ Relationship with Patient: _____

More About you

Do any of these describe you? ☐ I am a U.S. Veteran ☐ I am a Seasonal Farmworker

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Other: _____ ☐ I choose not to disclose

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Mexican American/Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____ ☐ I choose not to disclose

Alternate Housing (if applicable): ☐ Homeless (outdoors/street) ☐ Homeless shelter ☐ Doubling up ☐ Transitional housing ☐ Permanent supportive housing

Language & Accessibility Needs: Preferred Language: _____
☐ I will need a language interpreter for medical visits
☐ I am hearing impaired and need sign language services

Medical Planning

Preferred Pharmacy: If you wish to send prescriptions to HFHC Pharmacy, please choose:
☐ Silver Springs Blvd. ☐ Belleview ☐ South Pine – Drive Thru
Preferred Pharmacy Name and Address: _____

Advance Directives: Do you have a paper that says what you want for your medical care if you can't decide for yourself?
☐ YES ☐ NO

Section 2: Insurance Information (Copy of Insurance Card is Required)

Heart of Florida Health Center will bill your insurance for services covered based on their insurance plan. Parents/Guardians must provide accurate and up-to-date insurance information to avoid delays. If insurance details are not updated or coverage changes, it may affect proper billing.

☐ PATIENT HAS NO INSURANCE

	Primary	Secondary	Dental	Vision
Insurance Company:				
Employer:				
Policy Holder's Name:				
Policy Number:				
Policy Holder's Date of Birth:	____/____/_____	____/____/_____	____/____/_____	____/____/_____
Relationship with Patient:	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian

Section 3: Income Attestation – Self-Declaration (Required for All patients)

1. **Household Size** (Number of people in the household, as defined by tax dependency rules)
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+ (Specify: _____)

2. **Income Attestation** (Select the range that best represents your household's total income)
   ☐ $0 - $20,000
   ☐ $20,001 - $40,000
   ☐ $40,001 - $60,000
   ☐ $60,001 - $80,000
   ☐ $80,001 - $100,000
   ☐ $100,001 - $120,000
   ☐ $120,001 - $140,000
   ☐ Over $140,000

3. **Are you applying for the Sliding Fee Discount Program?**
   ☐ *Yes **(Complete Section #6)***
   ☐ *No: Please note:* By declining, I acknowledge that I am choosing to pay full fees for services received at Heart of Florida Health Centers Inc., including any fees not covered by my insurance. I agree to pay any balance in full.

Attestation Statement

*I certify that the information provided above is true to the best of my knowledge. I understand that this information may be subject to verification. I allow **Heart of Florida Health Center (HFHC)** to send bills and get payments from **Medicare, Medicaid, insurance, or other programs** that help pay for my medical care. I understand that if my insurance or program does not pay HFHC, I must pay for my care, including any copays, coinsurance, or deductibles. I agree to pay my bill on time.*

Print Name: _____ Relationship with Patient: Date:

Signature: _____ ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian ___/___/____

Section 4: Acknowledgment, Consent & Information Release

I understand that I have received or can request copies of the following:

☐ Patient-Centered Medical Home Guidelines
☐ Appointment Guidelines
☐ Notice of Privacy Practices
☐ Financial Practice and Procedures
☐ Patient Bill of Rights & Responsibilities
☐ Healthcare Advanced Directives: The Patient's Right to Decide

Consent for Care & Treatment

I give HFHC permission to provide me with medical, dental, nursing, and other healthcare services. This includes:

1. Check-ups, tests, shots, X-rays, lab work, and medicines
2. Mental health care, telehealth, and referrals if needed
3. Any treatment my provider thinks is necessary unless I say no

I understand that:

- No treatment is guaranteed to work. I can say no to any treatment at any time.
- If HFHC cannot treat my condition, they will tell me where I can go for help.
- My provider may take X-rays, pictures, or other tests to check my health. HFHC owns these records but can provide copies for a fee.
- My provider may use assistants if needed. Some medicines (like numbing shots) have small risks.
- HFHC may share my shot records with schools as required by law.
- HFHC may send my health information to Medicaid, Medicare, Social Security, and insurance to help with billing.
- HFHC may contact me by phone, text, or email. I can ask them to stop at any time. Standard message and data rates may apply.
- HFHC may use my health and prescription records for my treatment, billing, and daily operations.

Authorization to Share My Health Information

I can allow family members or friends to access my health information. The people listed below may receive details about my appointments, treatments, test results, and billing.

Name of Authorized Person	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Initial here) _____ I allow **HFHC** to share my health information with the people listed above.

I understand that:

- I can remove someone from this list at any time.
- This does not apply to information already shared before I revoked it.
- Once information is shared, federal privacy rules may no longer protect it.

I have read this form and understand it. I had a chance to ask questions. This consent remains valid until I cancel it in writing.

Print Name: _____ Relationship with Patient: Date:

☐ Self ☐ Legal Custodian

Signature: _____ ☐ Parent ☐ Legal Guardian ___/___/____

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Section 5: Patient Medical Information Form

Patient Current Medications

Please include Medication Name, Dose and Times per day Taken. *(vitamins, inhalers, prescriptions, other)*

_____

_____

_____

_____

_____

Patient Medical History (Check all that may apply)

- ☐ Allergies or Skin Conditions (e.g., Eczema, Rashes) → List: _____
- ☐ Blood Disorders (e.g., Anemia, Sickle Cell) → List: _____
- ☐ Bone, Joint, or Muscle Conditions (e.g., Arthritis, Cerebral Palsy, Spine Issues) → List: _____
- ☐ Breathing Issues (e.g., Asthma, Chronic Cough, Pneumonia) → List: _____
- ☐ Cancer (e.g., Leukemia) → List Type: _____
- ☐ Dental Issues (e.g., Tooth Pain, Bleeding Gums, Jaw Problems - TMJ) → List: _____
- ☐ Developmental or Learning Conditions (e.g., Autism, ADHD, Delays) → List: _____
- ☐ Diabetes or Frequent Thirst
- ☐ Digestive or Liver Problems (e.g., Stomach Issues, Hepatitis) → List: _____
- ☐ Heart or Circulation Problems (e.g., Heart Disease, High Blood Pressure, Pacemaker) → List: _____
- ☐ History of Blood Transfusions
- ☐ Infectious Diseases (e.g., Tuberculosis, STDs) → List: _____
- ☐ Kidney or Urinary Issues (e.g., Frequent Infections, Kidney Disease) → List: _____
- ☐ Mental Health Concerns (e.g., Anxiety, Depression) → List: _____
- ☐ Premature Birth
- ☐ Reproductive Health Issues (e.g., Pregnancy, PCOS) → List: _____
- ☐ Seizures or Neurological Issues (e.g., Epilepsy, Stroke, Fainting, Dizziness) → List: _____
- ☐ Substance Use (e.g., Alcohol, Drugs) → List: _____
- ☐ Taking Bone Hardening Medications (Bisphosphonates)
- ☐ Thyroid Problems
- ☐ Tobacco or Vaping Use
- ☐ Vision or Hearing Issues (e.g., Glasses, Hearing Aids) → List: _____
- ☐ Weakened Immune System (e.g., HIV/AIDS, Organ Transplant) → List: _____
- ☐ **Other Health Concerns** → Please Explain: _____

Patient Allergies

Food/Insects/Animals/Seasonal Allergies	☐ Yes	☐ No	Specify: _____
Medication Allergies	☐ Yes	☐ No	Specify: _____
Latex Allergies	☐ Yes	☐ No	Specify: _____

Reaction to Immunizations ☐ Yes ☐ No If Yes, State which Vaccine and describe Reaction: _____

Past Hospital Stays ☐ Yes ☐ No Explain: _____

Past Surgeries ☐ Yes ☐ No Explain: _____

ER visits in past year ☐ Yes ☐ No Reasons for Visits: _____

Family Medical History Check all that apply and list the affected relative(s) (e.g., Parent, Sibling, Grandparent).

- ☐ Anemia
- ☐ Stroke
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Seizures
- ☐ SIDS
- ☐ AIDS/HIV
- ☐ Sickle Cell
- ☐ Asthma
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Migraines
- ☐ Arthritis
- ☐ Dental Issues
- ☐ Alcohol/Drug Abuse
- ☐ High Cholesterol
- ☐ Other: _____

Affected Relative(s):

_____

_____

_____

Signature of Patient, Parent or Guardian: _____ Date: ___/___/_____

Provider Signature: _____ Date: ___/___/_____

Section 6: Sliding Fee Discount Application

(Complete this section **only if applying** for the Sliding Fee Discount Program.)

Proof of Income (Check all that apply.)	***Government-Issued Identification (Required for all applicants.)***
☐ *Wages and Federal Tax Statement (e.g., W-2)* ☐ *Recent Paystubs* ☐ *Determination or Benefits Verification Letter* ☐ *Self-Employment Ledger Documentation* ☐ *Employer Statement (Signed on company letterhead)* ☐ *Other: _____* ☐ ***No Proof of Income Provided (Complete Self-Declaration of No Income below)***	☐ *Driver's License* ☐ *Passport* ☐ *U.S. Immigration Form* ☐ *Other:* _____

Section 7: Declaration of No Income

(Complete only if you selected "No Proof of Income Provided" above.)

1. **I confirm that I do not receive money from any of the following sources:**
   - *Wages from a job (including tips, bonuses, or commissions)*
   - *Money from my own business*
   - *Rent payments from property I own*
   - *Interest or dividends from savings or investments*
   - *Social Security, retirement, pension, or insurance payments*
   - *Unemployment or disability benefits*
   - *Government assistance (such as food stamps or cash aid)*
   - *Alimony, child support, or financial help from someone outside my household*
   - *Money from selling products (e.g., Avon, Mary Kay, etc.)*
   - *Other income*

2. **Certification of Financial Support**
   I confirm that I have no income right now and do not expect any changes soon. If my financial situation changes, I will inform Heart of Florida Health Centers Inc. My basic needs (housing, food, utilities) are covered by:

Name: _____ or **Agency (if applicable):** _____
Phone: _____ **Address:** _____

3. **Acknowledgment & Certification**
   I confirm that the information I provided is true and correct to the best of my knowledge. I understand that giving false, incomplete, or misleading information may result in losing assistance from **Heart of Florida Health Centers Inc.**

Print Name: _____ Relationship with Patient: ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian Date: ___/___/_____

Signature: _____

Section 8 {MINORS ONLY}: Authorization for Another Adult to Make Health Care Decisions for My Child

I/We, _____ and _____,
am/are the

☐ parent(s) (natural guardian(s), ☐ legal custodian(s), ☐ legal guardian(s) Of:

Child's Name: _____ Date of Birth: ___/____/_____

Under **Florida law (s. 765.2035 and s. 744.301(1))**, I/We allow the following person to make medical, dental, and behavioral health decisions for my/our child if I/we are not available:

Primary Authorized Individual(s):

Name	Address	Phone Number

Backup Authorized Individual(s) (if the primary person is unavailable):

Name	Address	Phone Number

What This Means

- I/We allow **Heart of Florida Health Centers (HFHC)** to follow the instructions of the person(s) listed above for my child's medical care, including medicines, treatments, and procedures.
- These individuals can make health care decisions for my child, apply for benefits to help pay for care, and approve hospital or clinic transfers if needed.
- I/We understand that HFHC is **not responsible** for any decisions made by the person(s) listed above.
- I/We can cancel this permission at any time in writing.

Who Can Bring My Child for Care: By Florida law, **stepparents, grandparents, adult siblings, aunts, or uncles** can bring a child for medical care **without special permission.**

☐ I do NOT want this provision to apply. I want ONLY the person(s) listed in the tables above to be allowed to bring my child for care.

Print Name: _____ Relationship with Patient: Date:

☐ Self ☐ Legal Custodian

Signature: _____ ☐ Parent ☐ Legal Guardian ___/___/_____

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