HOPEHEALTH
YOUR HEALTH BEGINS HERE

Patient Registration Form

Section 1: Patient Information

First Name: _____ **Last Name:** _____ **MI:** _____

SSN: _____ **Sex assigned at birth** ☐ Male ☐ Female **Date of Birth:** _____ **Age:** _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Work Phone:** _____ **Cell phone:** _____

Email Address: _____

Primary language spoken at home: _____ **Interpreter needed:** ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Refuse to report

Emergency Contact: _____ **Relationship to patient:** _____ **Phone:** _____

Do we have permission to share medical information with the emergency contact? ☐ No ☐ Yes

If under the age of 18, please provide Parent/Guardian name(s):

Please select one answer per question and provide additional information when required:

Are you a student? ☐ No ☐ Yes, which school? _____

Military Status: ☐ Actively Serving ☐ Veteran ☐ Reserves ☐ N/A

Are you a migrant farm worker? ☐ No ☐ Yes ☐ Seasonal

Are you Hispanic, Latino or Chicano? ☐ No ☐ Yes ☐ Refuse to report

Please check which of the following best describes employment status.

☐ Employed Full time ☐ Employed Part Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Other

We must be able to contact you to give you results. Please check all ways we may contact you:

☐ Call home ☐ Call cell phone ☐ Text Message ☐ Mail to home address

☐ Call work ☐ Permission to leave message ☐ Email ☐ Other – please specify:

Please check with of the following best describes your current housing. Please select only one.

☐ Home-owner /Renter ☐ Permanent Supporting Housing ☐ Homeless ☐ Public Housing ☐ Unknown

☐ Other – please specify:

Please check which of the following best describes your race.

☐ White ☐ Black or African American ☐ Native Hawaiian ☐ Asian

☐ American Indian or Native Alaskan ☐ Pacific Islander ☐ Unknown/ Refuse to report ☐ Other – please specify:

Please check which of the following best describes your sexual orientation.

☐ Straight / Heterosexual ☐ Lesbian, gay or Homosexual ☐ Bisexual ☐ Don't know ☐ Something else ☐ Choose not to disclose

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Please check which of the following best describes your gender identity.

☐ Male ☐ Female ☐ Transgender male / female-to-male ☐ Transgender female / male-to-female ☐ Other ☐ Choose not to disclose

Section II: Insurance and Guarantor Information

Please check the type(s) of insurance coverage that you have: ☐ Medicaid/Medicare ☐ Other Medical Insurance ☐ Dental Insurance ☐ None

Insurance Name: _____ **Policy Number:** _____ **Group Number:** _____

Name of insured: _____

Relationship to Patient: _____ **Date of Birth:** _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Work Phone:** _____ **Cell phone:** _____

Social Security # _____ **Drivers' License #** _____

Employer Name: _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Are you interested in applying for our Sliding Fee Discount Program? ☐ No ☐ Yes ☐ I would like more information

If you choose to apply for our sliding fee scale discount, verification of income as well as completion of other forms will be required.

Secondary Insurance and Guarantor Information

Please check the type(s) of insurance coverage that you have: ☐ Medicaid/Medicare ☐ Other Medical Insurance ☐ Dental Insurance ☐ None

Secondary Insurance: _____ **Policy Number:** _____ **Group Number:** _____

Name of insured: _____

Relationship to Patient: _____ **Date of Birth:** _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Work Phone:** _____ **Cell phone:** _____

Social Security # _____ **Drivers' License #** _____

Employer Name: _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Section IV: Other Required Information

Are you a current patient at HopeHealth? ☐ Yes ☐ No If yes, who is your HopeHealth provider?

NEW PATIENTS ONLY:
How were you referred to us?

☐ Hospital ☐ School ☐ Work ☐ Employee ☐ Family
☐ Friend ☐ Radio ad ☐ Internet ☐ Billboard ☐ Other
☐ Physician *Name of referring Physician:*

Do you prefer a male provider or a female provider? ☐ Male ☐ Female ☐ No preference

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of the document may be used as the original document. I certify that this information is true and correct to the best of my ability.

Signed: ***Date:***