PrimeCareHealth
COMMUNITY HEALTH CENTERS

# Patient Registration

**Medical Record #**
*(For Office Use Only)*

**Legal Name:*** Last First Middle Initial **Name used:**

**Legal Sex (please check one):*** □Female □Male **Pronouns:**

**While PrimeCare recognizes a number of genders / sexes, many insurance companies and legalentities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred nameand pronouns are different from these, please let usknow.*

**Date of Birth:** Month Day Year | **Social Security #:** | **Email address:**

***Your answers to the following questions will help us reach you quickly and discreetly with importantinformation.***

| **Home Phone:** ( ) - **Ok to leave voicemail?** □Yes □No | **Cell Phone**: ( ) - **Ok to leave voicemail?** □Yes □No | **Work Phone**: ( ) - **Ok to leave voicemail?** □Yes □No | **Best number to use:** □Home □Cell □Work |
|---|---|---|---|

**Address:** Street City State ZIP

**Occupation:** Employer/School Name: Are you covered under school or employer's insurance? □Yes □No

**Emergency Contact's Name:** Phone Number: Relationship to you:

*If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.*
**Parent/Guardian Name:** Phone Number: Relationship to you:

***PrimeCare will send certain correspondence, such as bills, to your mailing address*. How would you prefer toreceive other types of written correspondence?** *(check one)*
□Secure Email (MyChart) □Letter □Other

***This information is for demographic purposes only and will not affect your care.***

**1.) What is your annual income?**

□$0-$15,000 □$45,001-$60,000
□$15,001-$30,000 □$60,001-$75,000
□$30,001-$45,000 □Over $75,000
□Prefer not to answer

How many people (including you) does your income support?

_____

**2.) Employment Status:**

□Employed full time
□Employed part time
□Seasonal
□Disabled
□Retired
□Unemployed
□Student

**3.) Racial Group(s):**
*(check all that apply)*

□African American / Black
□Asian
□Caucasian / White
□Native American / Alaskan Native / Inuit
□Pacific Islander
□Multiracial
□Decline to answer

**4.) Ethnicity**

□Hispanic/Latino/Latina
□Not Hispanic/Latino/Latina
□Decline to answer

**5.) Country of Birth**
□USA
□Other: _____

**6.) Preferred Language:**
*(choose one)*

□English
□Español
□Français
□Português
□Polskie
□Other _____

**7.) Do you think of yourself as:**

□Lesbian, gay, or homosexual
□Straight or heterosexual
□Bisexual
□Something else
□Don't know
□Choose not to disclose

**8.) Marital Status:**

□Married
□Partnered
□Single
□Divorced
□Other_____

**9.) Veteran Status:**

□Veteran
□Not a Veteran

**10.) Housing:**

Are you a resident of public housing?
□Yes □No

Are you homeless? □Yes □No

If yes, where do you stay at night?
□Shelter □Street
□Transitional □Doubling up
□Other _____

**11.) What is your gender identity?**

□Female
□Male
□Transgender Male / Female-to-Male
□Transgender Female / Male-to-Female
□Other
□Decline to answer

**12.) What was your sex assigned at birth?**

□Female
□Male

**13.) Health Care:**

Do you have a health care proxy? □Yes □No

Do you have advanced directives (living will, power of attorney)? □Yes □No

Do you require day to day care? □Yes □No

If yes, who is your primary care giver?

_____

Do you have physician orders for life sustaining treatment? □Yes □No

***PLEASE TURN OVER***

PrimeCareHealth
COMMUNITY HEALTH CENTERS

# Patient Consent for Treatment

Patient Name:_____ Date:_____

**Consent to Treatment** I authorize PrimeCare Community Health, Inc. (PCH) and its medical, nursing, behavioral health and other professional staff members, to provide health care services and to administer diagnostic and therapeutic procedures and treatments as, in the judgment of PCH's medical personnel, are deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by PCH personnel.

**Assignment of Benefits** I assign to PrimeCare Community Health 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 PCH.

**Financial Obligations** I agree, that, except as may be limited by law or PCH'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 PHC facilities in accordance with the rates and terms of PCH in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

**I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.**

Patient or Responsible Party Signature: _____ Date: _____

Nature of Relationship to Patient (if patient not signing): _____