Bethel Family Clinic

PATIENT REGISTRATION FORM

OFFICE USE ONLY:
Account #: _____
*CHC Discount %:*_____
Reviewed by: _____

PATIENT INFORMATION:

Last/ First Name _____/_____ Middle: ___Date of Birth: _____

SSN: _____

P O Box/Street Address

Address: _____

_____

City: _____

State: _____ Zip: _____

Phone - Home: _____

Work: _____

Email: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship to Patient: _____

PATIENT EMPLOYER

NAME of EMPLOYER_____

Phone: _____

PATIENT DEMOGRAPHIC INFORMATION:

Our federal grant requires us to collect and report on this information. The information is reported on the population as a whole, not by specific individual.

Race: ❑ White ❑ Black/African American ❑ Alaska Native/American Indian
❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander
❑ Other ❑ Unknown ❑ More than one race

Ethnic Identity: ❑ Hispanic / Latino ❑ Other

Veteran Status: ❑ Yes ❑ No (have you been discharged from the U.S. military?)

Primary Language: ❑ English ❑ Other: please identify_____

Interpreter Required? ❑ Yes ❑ No

Gender Identity: ❑ Male ❑ Female

❑ Female-to-Male (FTM)/Transgender Male/Trans Man ❑ Male-to-Female (MTF)/Transgender Female/Trans Woman

❑ Gender queer, neither exclusively male nor female ❑ Additional Gender Category/ (or other), please specify

❑ Decline to Answer

Sexual Orientation: ❑ Lesbian, Gay, or Homosexual ❑ Straight or Heterosexual
❑ Bisexual ❑ Something else ❑ Don't Know ❑ Decline to Answer

SLIDING SCALE DISCOUNT PROGRAM:

Bethel Family Clinic offers a sliding scale discount based on family size and income. Please complete the sliding scale discount application form to determine your eligibility.

Revised: February 2016

NOTE: *If you want uninterrupted medication issues, you need to notify us **14 days** in advance in order for your medication to arrive on time.*

Do you have an Account with any Pharmacy: ☐ **Yes** ☐ **No**
If no, a list of pharmacies will be provided to you. It is your responsibility to create your account and notify the clinic.

Preferred Mail Order Pharmacy Information

Pharmacy Name: _____

Pharmacy Telephone: _____

Complete Address of Pharmacy: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Policy #: _____

Policy Holder Name: _____ Group #: _____

Date of Birth: _____ SSN: _____ Gender: ❑ Male ❑ Female

Relationship to Patient: _____

Policy Holder Employer: _____ Employer Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Policy #: _____

Policy Holder Name: _____ Group #: _____

Date of Birth: _____ SSN: _____ Gender: ❑ Male ❑ Female

Relationship to Patient: _____

Policy Holder Employer: _____ Employer Phone: _____

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the Bethel Family Clinic. I understand that I am financially responsible for amounts not covered by my insurance or beneficiary status.

I hereby consent for the Bethel Family Clinic to administer treatments and to perform medical or procedures as necessary.

SIGNATURE: _____ **Date:** _____
(Patient, Parent or Guardian)

PRIVACY PRACTICES ACKNOWLEDGEMENT:

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review the Notice.

Printed Name: _____

Signature: _____ **Date:** _____