Salud
Family Health

Minor(s) Only Patient Registration Form

Use this form to register your minor(s) for care when you (the guardian) are NOT establishing care yourself

As a Federally Qualified Health Center, we are required to request some personal information regarding both you and the minor(s) in your care. All information provided will be kept confidential.

Please fill out the following information to register your minor(s) for our services.

Parent / Legal Guardian Information:

First Name: __________________ **Middle Initial**: ______ **Last Name**: __________________________________

Address: ____
City: ______________________________________ **State**: _________________ **Zip Code**: __________________

Preferred Phone: ☐Home ☐Cell **Home Phone**:___________________ **Cell Phone**:_____________________

Email Address:____
(for access to patient portal for minors 12 years and younger)

DOB:_____________ **Social Security Number**:_________________ **Language Preference**: __________________

Please enter information for minor (additional minors may be added on page 4):

First Name: __________________ **Middle Initial**: ______ **Last Name**: __________________________________
Name minor goes by: ____
Address *(If different from guardian)*: ____
City: ______________________________________ **State**: _________________ **Zip Code**: ___________________
DOB:______________________ **Social Security Number**: ____

What was the minor's sex assigned at birth? ☐Female ☐Male ☐Unknown

What is their gender identity?: ☐Female ☐Male ☐Genderqueer/Non-conforming ☐Other: ___________
☐Transgender boy (female to male) ☐Transgender girl (male to female) ☐ Choose not to disclose

Is the minor currently experiencing homelessness? ☐Yes ☐No

Does the minor live in public housing (i.e., Section 8, a half-way house etc.)? ☐Yes ☐No

What is the minor's ethnicity? ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify

What is the minor's race? ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐ White ☐Declined to Specify

Does the minor have health coverage? ☐Yes ☐No
Name of insurance (please provide a copy of insurance card):____
Insurance Holder's Name:____

Salud Family Health receives special funding to provide discounted services to certain patient populations. Please answer the following questions:

1. At any time in the past two years, have you or anyone in your family had a job working with or transporting plants, trees, or farm animals? ☐Yes ☐No
2. If so, to do that work, have you had to establish a temporary home? ☐Yes ☐No
3. At any time did you or anyone in your family retire from a job working with or transporting plants, trees, or farm animals? ☐Yes ☐No

As a Federally Qualified Health Center, Salud is required to ask about household income and family size.
What is your estimated household income before taxes?
Monthly:________________ or Annual:__________________

How many financial dependents are in your household (including yourself and your spouse)?_________

What is your preferred pharmacy? ☐ Salud Pharmacy **Other Pharmacy**: _________________________

Pharmacy Address:____

List an emergency contact in the event of an emergency. This does not grant them access to the minors' health information.

Emergency Contact Name:___________________________________ Relationship:_________________

Phone Number:____

Optional: Health Information Access - If there is anyone else with whom you would like to share the minors' health information, you may designate that person below.

We will share the minors' health information as needed with this person. We may call, text, or leave voice messages at their specified phone number. We will also answer questions they may contact us with.

I give permission for my minors' protected health information to be disclosed to the person listed below:

Name:_____________________________________ Relationship to Minor:________________________

Address:____

Phone number:____

Electronic Consents - The phone numbers you provided will be used to message you via text and/or voice about appointment reminders and to reach you about results or telehealth visits. It is your responsibility to maintain your contact information current with us so we may reach you. If you would like to receive communications via alternative means or at alternative locations, please advise a Salud staff member. Salud participates in electronic health information exchanges to share the minors' health information with other health care providers when relevant to their care, such as for hospitals visits. You have the option of opting the minors' out of this health information exchange if you choose.

Do you want to opt out of having the minors' health information shared in any health information exchange? ☐ Yes - Opt Out ☐ No - Allow information exchange

Parent/Guardian First and Last Name: ________________________________

The following documents provide information regarding your care at Salud Family Health. Your initials and signature below indicate that you have received a copy of each document, understand the information, and agree to the terms and conditions outlined.

_______ **Consent for Treatment** - This document allows you and any family members 17 and younger to which you are a parent or legal guardian to receive medical, behavioral health and dental treatment at Salud Family Health Center.

_______ **Patient Rights and Responsibilities** - This document explains your rights and responsibilities as a Salud patient, including your right to be treated with respect and dignity and your responsibility to be considerate and respectful towards Salud's health care team.

_______ **Salud is Your Medical Home** - This document explains what it means to be a Medical Home, including using a team-based approach to patient care and empowering you to be responsible for your own health care.

_______ **Patient Financial Rights and Responsibilities** - This document provides details on how Salud collects fees for the services we provide, including the expectation for you to make a payment for your portion of fees before services are delivered.

_______ **Missed and Late Appointment Policy** - This document provides details on the consequences of arriving more than fifteen minutes late for an appointment or not calling to cancel your appointment by 4pm the day prior to your scheduled appointment if you need to reschedule or cancel it.

_______ **HIPAA Notice of Private Practices** - This notice provides information on how we keep your information private and ways we may share your healthcare information.

Print Name:____ Date:_________________________

Signature:____

(Your signature authorizes care for the minor(s) you have listed on this registration form)

ADDITIONAL MINORS

Please enter information for additional minor:

First Name: __________________ **Middle Initial**: ______ **Last Name**: __________________________________
Name minor goes by: ____
Address *(If different from guardian)*: ____
City: _______________________________________ **State**: _________________ **Zip Code**: __________________
DOB:______________________ **Social Security Number**: ____

What was the minor's sex assigned at birth? ☐Female ☐Male ☐Unknown
What is their gender identity?: ☐Female ☐Male ☐Genderqueer/Non-conforming ☐Other: ___________
☐Transgender boy (female to male) ☐Transgender girl (male to female)

Is the minor currently experiencing homelessness? ☐Yes ☐No
Does the minor live in public housing (i.e., Section 8, a half-way house, etc.)? ☐Yes ☐No

What is the minor's ethnicity? ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify
What is the minor's race? ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐White ☐Declined to Specify

Does the minor have health coverage? ☐Yes ☐No
Name of insurance (please provide a copy of insurance card): ____
Insurance Holder's Name:____

Please enter information for additional minor:

First Name: __________________ **Middle Initial**: ______ **Last Name**: __________________________________
Name minor goes by: ____
Address *(If different from guardian)*: ____
City: _______________________________________ **State**: _________________ **Zip Code**: __________________
DOB:______________________ **Social Security Number**: ____

What was the minor's sex assigned at birth? ☐Female ☐Male ☐Unknown
What is their gender identity?: ☐Female ☐Male ☐Genderqueer/Non-conforming ☐Other: ___________
☐Transgender boy (female to male) ☐Transgender girl (male to female)

Is the minor currently experiencing homelessness? ☐Yes ☐No
Does the minor live in public housing (i.e., Section 8, a half-way house, etc.)? ☐Yes ☐No

What is the minor's ethnicity? ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify
What is the minor's race? ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐White ☐Declined to Specify

Does the minor have health coverage? ☐Yes ☐No
Name of insurance (please provide a copy of insurance card): ____
Insurance Holder's Name:____