Salud Family Health Centers
EXCELLENCE. EVERY PATIENT. EVERY TIME.

Patient Registration Form

Personal Information- For patients 18+ or Parents/Legal Guardian information for patients who are children

Last Name_____ **First Name**_____ **Middle Initial** _____

Preferred Name_____ **Language Preference**_____

Address_____ **City**_____ **State**_____ **Zip Code** _____

SS#_____ **DOB**____/____/_____ **Email Address** _____

Please mark the "P" box for your preferred phone number.

P ☐ **Home Phone**_____ **P**☐ **Cell Phone**_____ **P**☐ **Work Phone**_____

What was your sex assigned at birth? ☐ Female ☐ Male ☐ Intersex ☐ Unknown ☐ Other _____

What is your gender identity? ☐ Female ☐ Male ☐ Genderqueer/Non-Conforming ☐ Other _____

☐ Transgender Male/Trans Man (Female to Male) ☐ Transgender Female/Trans Woman (Male to Female)

What is your sexual orientation? ☐ Lesbian ☐ Gay ☐ Straight ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ Other_____

Are you currently homeless? Yes No **Do you live in public housing?** Yes No

Employment Status: ☐ Full Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Active Military ☐ Student

Are you a veteran? ☐ Yes ☐ No **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other_____ ☐ Declined to Specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ Black or African American

☐ Other_____ ☐ Declined to Specify

Do you have any of the following? ☐ Living Will* ☐ Power of Attorney ☐ DNR (Do Not Resuscitate) Order ☐ None

*A Living Will explains what medical treatment you'd like if you are unable to communicate your desires

Salud Family Health Centers 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

Household Income and Family Size

Estimated Household Income (before taxes) _____ Monthly ☐ Annual

Number of financial dependents living in your household (including yourself and spouse if applicable) _____

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Patient First and Last Name_____ Patient Date of Birth _____

Health Insurance Information

Name of Insurance_____ (Please provide a copy of your insurance card)

Insurance Holder's Name _____

HIPAA Consents

After reviewing the Notice of Privacy Practice, do you want to designate a family member or other individual with whom we may disclose your medical information?

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care to the person(s) listed below:

Name	Relationship	Contact Phone Number	Specific Notes

Please enter below who we can contact in the event of an emergency. Please note that this does not grant them access to your health information, unless you specify otherwise.

Emergency Contact	Relationship	Contact Phone Number	Specific Notes

Also note the phone numbers you provided for yourself on page 1 will be used to message you via text and voice about appointment reminders and to reach you about results or needed appointments. We may call, text or leave voice messages with anyone you designated to share your information with above as needed. It is your responsibility to maintain your 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.

☐ I opt OUT of receiving text communications

Salud participates in electronic health information exchanges to share your health information with other health care providers when relevant to your care, such as hospitals you've visited. You have the option of opting out of this health information exchange if you choose.

☐ I opt out of having my health information shared on any health information exchange

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Patient First and Last Name _____ Patient Date of Birth _____

Consents:

The following forms provide information regarding your care at Salud Family Health Centers. You have received a copy of each document. Your initials and signature below indicate that you received a copy, 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 Centers.

_____ **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: _____

(Signing this form authorizes care for both yourself and any dependents you have included on the child registration form)

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Responsible Party _____

Child/Minor/Dependent Registration Form

Last Name_____ **First Name**_____ **Middle Initial** _____

Address (if different from parent or guardian) _____

City_____ **State**_____ **Zip Code** _____

DOB_____ **Birth Sex**_____ ☐ Transgender **Social Security Number**_____

Patient Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other_____ ☐Declined to Specify

Patient Race: ☐American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ Black or African American ☐Other_____ ☐ Declined to Specify

Emergency Contact Information:

Name_____ **Phone Number** _____

Relationship to Patient _____

Name of Insurance_____ **Insurance Holder** _____

Additional Child/Minor/Dependent Registration Form

Last Name_____ **First Name**_____ **Middle Initial** _____

Address (if different from parent or guardian) _____

City_____ **State**_____ **Zip Code** _____

DOB_____ **Birth Sex**_____ ☐ Transgender **Social Security Number**_____

Patient Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other_____ ☐Declined to Specify

Patient Race: ☐American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ Black or African American ☐Other_____ ☐ Declined to Specify

Emergency Contact Information:

Name_____ **Phone Number** _____

Relationship to Patient _____

Name of Insurance_____ **Insurance Holder** _____

Additional Child/Minor/Dependent Registration Form

Last Name_____ **First Name**_____ **Middle Initial** _____

Address (if different from parent or guardian) _____

City_____ **State**_____ **Zip Code** _____

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Emergency Contact Information:

Name_____ **Phone Number** _____

Relationship to Patient _____

Name of Insurance_____ **Insurance Holder** _____