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:** _____

Phone *(please check preferred)*: ❑ **Home:** _____ ❑ **Cell:** _____

Email address *(for access to patient portal for adults and minors 12 years and younger)*: _____

DOB: MM/DD/YYYY **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: MM/DD/YYYY **Social Security Number:** _____

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

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

Minor's ethnicity: ❑ Not Hispanic, Latino/a or Spanish origin ❑ Hispanic, Latino/a or Spanish origin ❑ Decline to specify

If Hispanic, Latino/a or Spanish origin, is the minor?: ❑ Mexican, Mexican American, Chicano/a ❑ Puerto Rican ❑ Cuban ❑ Another Hispanic/Latino/a or Spanish Origin (please specify from where): _____ ❑ Combo of Hispanic, Latino/a, Spanish origins (specify from where): _____ ❑ Decline to specify

Race: ❑ American Indian/Alaska Native ❑ Black/African American ❑ White ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Guamanian or Chamorro ❑ Samoan ❑ More than one (select all that apply) ❑ Other (please specify): _____ ❑ Decline to specify

MINOR(S) ONLY PATIENT REGISTRATION FORM

Does the minor have health coverage? ❑ Yes ❑ No

Name of insurance *(please provide a copy of insurance card)*: _____

Insurance Holder's Name: _____ **DOB:**_____ MM/DD/YYYY

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: _____

Parent/Guardian First Name: _____ Last Name:_____

MINOR(S) ONLY PATIENT REGISTRATION FORM

The following documents provide information regarding your minors´ 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 any family members 17 and younger you have listed on this registration form to which you are a parent or legal guardian to receive medical, behavioral health and dental treatment at Salud Family Health.

_____ **PATIENT RIGHTS AND RESPONSIBILITIES** - This document explains your rights and responsibilities as the parent or legal guardian of the Salud patient(s) in your care, including their right to be treated with respect and dignity and your/their 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 Salud patients to be responsible for their 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 an appointment by 4pm the day prior to the scheduled appointment if you need to reschedule or cancel it.

_____ **HIPAA NOTICE OF PRIVATE PRACTICES** - This notice provides information on how we keep Salud patients' information private and ways we may share patients' healthcare information.

Print Name: _____ **Date:** _____

Signature: _____

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

Parent/Guardian First Name: _____ Last Name: _____

MINOR(S) ONLY PATIENT REGISTRATION FORM

ADD A MINOR REGISTRATION FORM *(Use this form to add minor(s) to a Patient Registration form)*

Minor First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Name minor goes by: _____

Address *(If different from guardian)*: _____

City: _____ **State:** _____ **Zip Code:** _____

DOB: _____ MM/DD/YYYY **Social Security Number:** _____

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

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

Minor's ethnicity: ❑ Not Hispanic, Latino/a or Spanish origin ❑ Hispanic, Latino/a or Spanish origin ❑ Decline to specify

If Hispanic, Latino/a or Spanish origin, is the minor?: ❑ Mexican, Mexican American, Chicano/a ❑ Puerto Rican ❑ Cuban
❑ Another Hispanic/Latino/a or Spanish Origin (please specify from where): _____
❑ Combo of Hispanic, Latino/a, Spanish origins (specify from where): _____ ❑ Decline to specify

Race: ❑ American Indian/Alaska Native ❑ Black/African American ❑ White ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Guamanian or Chamorro
❑ Samoan ❑ More than one (select all that apply) ❑ Other (please specify): _____ ❑ Decline to specify

Does the minor have health coverage? ❑ Yes ❑ No

Name of insurance *(please provide a copy of insurance card)*: _____

Insurance Holder's Name: _____ **DOB:** _____ MM/DD/YYYY

Minor First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Name minor goes by: _____

Address *(If different from guardian)*: _____

City: _____ **State:** _____ **Zip Code:** _____

DOB: _____ MM/DD/YYYY **Social Security Number:** _____

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Does the minor have health coverage? ❑ Yes ❑ No

Name of insurance *(please provide a copy of insurance card)*: _____

Insurance Holder's Name: _____ **DOB:** _____ MM/DD/YYYY