Health Ministries Clinic
COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

FULL NAME			
SSN#	**DATE OF BIRTH** (MM/DD/YY)	**GENDER AT BIRTH** ☐ M ☐ F	
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
MAILING ADDRESS (IF DIFFERENT FROM ADDRESS)	**MAILING CITY**	**MAILING STATE**	**MAILING ZIP CODE**
HOME PHONE	**CELL PHONE**	**WORK PHONE**	
ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME)	**MARITAL STATUS** ☐ S ☐ M ☐ D ☐ W		
EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)	**Employer:** ☐ FT ☐ PT ☐ PRN		

PHARMACY ☐ Health Ministries Clinic Pharmacy ☐ Other Pharmacy (specify): _____

RACE	**HOUSING** Are you currently experiencing homeless?	**GENDER IDENTITY**
☐ American Indian/Alaska Native	☐ Yes	☐ Male
☐ Asian	☐ No	☐ Female
☐ Black/African American	**IF YES:** are you utilizing any of the following?	☐ Transgender
☐ Native Hawaiian	☐ Homeless Shelter	☐ Decline to Specify
☐ Other Pacific Islander	☐ Transitional	☐ Other (please specify):
☐ White	☐ Doubling Up	**DO YOU LIVE IN PUBLIC HOUSING?**
(check all that apply)	☐ Street	☐ Yes
	☐ Other (please specify): _____	☐ No

DO YOU IDENTIFY AS HISPANIC/LATINO?	**POPULATIONS** Are you a:	**SEXUAL ORIENTATION**
☐ Yes	☐ Veteran	☐ Lesbian/Gay
☐ No	☐ Farm Worker	☐ Straight
PREFERRED LANGUAGE	☐ Migrant Worker	☐ Bisexual
	☐ Seasonal Worker	☐ I do not know
☐ English	***(check all that apply)***	☐ Decline to Specify
☐ Spanish		☐ Other (please specify): _____
☐ Other: _____	**COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE**	
☐ Interpreter Needed	Mother's Name	
	Father's Name	

RESPONSIBLE PARTY ☐ Check if same as patient

FULL NAME			
SSN#	**DATE OF BIRTH**		
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**CELL PHONE**	**WORK PHONE**	
EMAIL ADDRESS	**EMPLOYER**		

EMERGENCY CONTACT ☐ Check if same as Responsible Party

EMERGENCY CONTACT NAME			**PHONE #**		
Relationship to Patient	☐ Spouse	☐ Parent	☐ Child	☐ Other: _____	
EMERGENCY CONTACT NAME			**PHONE #**		
Relationship to Patient	☐ Spouse	☐ Parent	☐ Child	☐ Other: _____	

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PATIENT NAME:	DOB:

COMMUNICATION AUTHORIZATION

If you are not available, who may we communicate with? (Check all that apply)

I authorize Health Ministries Clinic to share my personal health information with the person(s) below. I understand this authorization is voluntary. I understand that once my information is disclosed, it may be disclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand this consent will remain in effect until I cancel it in writing.

☐ Communicate with Self Only If you are not available may we leave a voice message? ☐ Yes ☐ No

NAME:	RELATIONSHIP:	PHONE:						
			☐ Health Info	☐ Billing	☐ Scheduling	☐ All		
NAME:	RELATIONSHIP:	PHONE:						
			☐ Health Info	☐ Billing	☐ Scheduling	☐ All		
NAME:	RELATIONSHIP:	PHONE:						
			☐ Health Info	☐ Billing	☐ Scheduling	☐ All		

HOUSEHOLD INCOME

The following information is used to determine if you may qualify for discounted fees and services. This information can be updated at any time.

Have insurance? You still may qualify for a discount!

Sliding fee scales also apply for possible discounts at the pharmacy, along with medical appointments.

Number in Household	Annual Household Income				
	Slide A: $25.00	Slide B: $30.00	Slide C: $35.00	Slide D: $40.00	No Slide: (>200% of FPG)
1	☐ < $12,490	☐ $12,491-$18,735	☐ $18,736-$21,858	☐ $21,859-$24,980	☐ > $24,987
2	☐ < $16,910	☐ $16,911-$25,365	☐ $25,366-$29,593	☐ $29,594-$33,820	☐ > $33,821
3	☐ < $21,330	☐ $24,331-$31,995	☐ $31,996-$37,328	☐ $37,329-$42,660	☐ > $42,661
4	☐ < $25,750	☐ $25,751-$38,625	☐ $38,626-$45,063	☐ $45,064-$51,500	☐ > $51,501
5	☐ < $30,170	☐ $30,171-$45,255	☐ $45,256-$52,798	☐ $52,799-$60,340	☐ > $60,341
6	☐ < $34,590	☐ $34,591-$51,885	☐ $51,866-$60,533	☐ $60,534-$69,180	☐ > $69,181
7	☐ < $39,010	☐ $39,011-$58,515	☐ $58,516-$68,268	☐ $68,269 - $78,020	☐ > $78,021
8	☐ < 43,430	☐ $43,431-$65,145	☐ $65,146-$76,003	☐ $76,004 - $86,860	☐ > $86,861

☐ **More than 8 members in household**—*Please ask the Front Desk for additional information*

☐ I DO NOT QUALIFY FOR THE SLIDING FEE SCALE, AND I AM AT OR ABOVE **200%** OF FEDERAL POVERTY GUIDELINES (FPG)

FOR PATIENTS **UNDER AGE** 18 ONLY

I as the parent/legal guardian of the **minor** aged patient agree to allow the following persons to give consent for the treatment of said minor:

NAME	DOB	RELATIONSHIP TO MINOR
NAME	DOB	RELATIONSHIP TO MINOR
NAME	DOB	RELATIONSHIP TO MINOR

How did you hear about Health Ministries Clinic? ☐ Google ☐ Newspaper ☐ Social Media ☐ Flyers ☐ Radio Ad ☐ Billboard ☐ Friend ☐ Other

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Patient Name: _____ DOB: _____

PATIENT ACKNOWLEDGEMENT—NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS AND RESPONSIBILITIES
I acknowledge that Health Ministries Clinic (HMC) has given me the right to review and secure a copy of the Notice of Privacy Practices as well as the following documents, which describes how health information about me may be used and disclosed, as well as a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that HMC reserves the right to change the terms of this notice periodically, and that I may contact Health Ministries Clinic at any time to obtain the most current copy of these documents. I understand that if I have any questions regarding any of these documents, I can contact HMC. I acknowledge that Health Ministries Clinic (HMC) has given me the right to review and secure a copy of the patient's rights and responsibilities. I understand that if I have any questions regarding my rights, I can contact Health Ministries Clinic. ***A paper copy may be obtained at the front desk***
• Payment Agreement • Insurance Filing/Medicare • Attendance Agreement • Notice of Privacy Practice • Patient Rights and Responsibilities

I have answered the information (above) to the best of my knowledge and ability. I have been given the opportunity to review, and I fully understand, and accept, all terms and policies stated above.

_____ _____ _____
Patient/Parent or Guardian Name (PRINT) Patient/Parent or Guardian Signature Date

☐ **Patient/Parent or Guardian refuses to Acknowledge Receipt of Privacy Practices:**

_____ _____ _____
HMC Staff Name (PRINT) HMC Staff Signature Date

This area is to ***only*** be filled out by a Health Ministries Staff member, if patient needed help filling out this form and patient or patient's legal representative is present.

_____ _____ _____
HMC Staff Name (PRINT) HMC Staff Signature Date