Tri-Area Community Health _____ **LF** _____ **Floyd** _____ **Ferrum**

Patient Registration Form

Please print clearly your response to all requested information. If you have questions, please ask. THANK YOU!!!

Where did you hear about Tri-Area ◇ *College* ◇ *Community* ◇ *Family/Fr*
◇ *Health Dept/Social* ◇ *Newspaper* ◇ *Other*_____

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Patient Information

Patient's Full Name:_____ Sex at birth: M F
(FIRST) (MIDDLE) (LAST)

Address:_____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )_____-_____Work: ( )_____-_____DOB:_____/_____/_____(mm/dd/yyyy)

Email Address:_____Cell: ( )_____-_____Are you a veteran? (circle one) Yes No

Social Security #:_____/_____/_____ Marital Status: (circle one) S M D W (Single/Married/Divorced/Widowed) Age:_____

Employer:_____Phone No: ( )_____-_____

Employer's Address:_____
(STREET) (CITY) (STATE) (ZIP)

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Responsible Party Information ____ Yourself ____Spouse _____Parent ____ Other

Name:_____
(FIRST) (MIDDLE) (LAST)

Physical Address:_____
(STREET) (CITY) (STATE) (ZIP)

Mailing Address:_____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )_____-_____Work: ( )_____-_____DOB:_____/_____/_____(mm/dd/yyyy)

Employer:_____Phone No: ( )_____-_____

Employer's Address:_____
(STREET) (CITY) (STATE) (ZIP)

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Insurance Information

Who is the insurance policy holder?: (circle one) Self Spouse Parent - Mother or Father

Name of Policy Holder:_____
(FIRST) (MIDDLE) (LAST)

Social Security # or Policy ID#:_____Policy Holder DOB:_____

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Emergency Contact

Emergency contact other than spouse:_____Relationship to you:_____
(FIRST) (MIDDLE) (LAST)

Home Phone: ( )_____-_____Work Phone: ( )_____-_____

PREFERRED PHARMACY: _____
City _____ Phone number _____

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(Form continues on back)

The following information is for public health service grant purposes only. No personally identifiable information is ever reported. By providing this information, you help us continue to receive funding to provide services to the community and special populations. Please circle answers below.

RACE: White Black/African American Asian Pacific Islander American Indian

More than one race

Ethnicity: Are you Hispanic or Latino? Yes No

Preferred Language: English Spanish Other ____ Is an interpreter needed? Yes No

Is your main source of work for you or your family seasonal or migrant work? Yes No

Are you homeless? Yes No

If yes, where do you sleep at night? Shelter Street Stay with a friend Other

Annual household income (please circle one below). **Number of people in household _____**

0-$10,000	$25,000-29,999	$50,000-59,999	
$10,000-14,999	$30,000-34,999	$60,000-69,999	**Choose not to disclose**
$15,000-19,999	$35,000-39,999	$70,000-79,999	
$20,000-24,999	$40,000-49,999	$80,000-above	

Current gender: Male Female Other **Choose not to disclose**

Transgender: Male to Female Female to Male

Sexual Orientation: Straight Lesbian or Gay Bisexual **Choose not to Disclose**

Don't know Other

Form continues to page 3

AUTHORIZATIONS AND CERTIFICATIONS

I HEREBY AUTHORIZE THE FOLLOWING:

- ***Tri-Area Community Health*** **through its appropriate personnel and/or its medical staff to perform, administer, prescribe, or to have performed, administered, or prescribed upon, to, or for me or any members of my family (including minor children) whose names appear below, such examination, tests, immunizations, injections, and diagnostic procedures as are deemed necessary. I also certify that all information contained herein is true and correct to the best of my knowledge and belief, and that no facts have been omitted.**

- ***Insurance Authorization and Assignment*** **to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.**

- ***Medicare Lifetime Authorization*** **for physical services and request that payment of authorized Medicare benefits to make either to me or on my behalf to Tri-Area Community Health, Inc., d.b.a. Tri-Area Community Health, for any services furnished to me by their physicians. I authorize my holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.**

- ***Deemed Consent for Designated Blood borne Pathogens:***
  Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS virus) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.
  Under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Tri-Area Community Health is directly exposed to body fluids of a patient in a manner which may transmit HIV (AIDS virus) or Hepatitis B and C according to the guidelines of the Centers for Disease Control, Tri-Area Community Health will proceed to test the patient's blood for HIV and Hepatitis B and C. Tri-Area Community Health will provide the results of the test to the patient through his or her primary care provider, and to the health care worker who was exposed. Tri-Area Community Health's policy also protects you as a patient, should you be exposed to the body fluids of a health care worker.

- ***I ALSO CERTIFY*** **that I have read and understand the collection policy of Tri-Area Community Health and agree to abide by it._____(initials)**

- ***I ALSO CERTIFY*** **that I have read and understand the No Show Policy of Tri-Area Community Health and agree to abide by it._____(initials)**

THE INFORMATION PROVIDED ON THIS REGISTRATION FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_____ **DATE:**_____