HOMETOWN HEALTH CENTERS – ADULT PATIENT REGISTRATION

Patient Name: _____ Maiden Name: _____

Address: _____ Homeless ☐ Yes ☐ No

City: _____ State: _____ Zip Code: _____

Home #:_____ Cell #:_____ Work #:_____ SS #: _____ Sex: M____ F _____

Hometown Health Center can send reminders and messages by: (check for yes) Home phone ☐ Cell phone ☐ Work phone ☐ Text ☐

Date of Birth: _____ E mail: _____@ _____

Employer: _____

Guarantor/Parent 1/Parent 2 if not the patient (financially responsible party other than the patient):

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #:_____ Cell #:_____ Work #:_____ SS #: _____ Sex: M____ F _____

Hometown Health Center can send reminders and messages by: (check for yes) Home phone ☐ Cell phone ☐ Work phone ☐ Text ☐

Date of Birth: _____ E-mail: _____ @ _____

Employer: _____

(For reporting purposes only)
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Race: ☐ White ☐ Black/Afro- American ☐ Asian ☐ Pacific Islander ☐ Multi-race ☐ Native American ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to report

Primary Language: ☐ English ☐ Spanish Other: _____

Military Status: Are you a veteran? Yes ☐ No ☐

HOUSEHOLD INFORMATION

As a Federally Qualified Health Care Center, we need the following information for statistical reports

Approximate Annual Family Income: $ _____ Number of Family Members: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #:_____

Address: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Insurance Subscriber Name: _____

Secondary Insurance: _____ ID#: _____

Insurance Subscriber Name: _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone #:_____

Address/Location: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I Authorize Hometown Health Centers to release any information, including diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay, directly to Hometown Health Centers, group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby, certify that to the best of my knowledge all of the above information is true and correct. I understand that program officials may verify information on this form or use information for statistical analysis. I also understand that information I supply will be kept confidential.

Payment is expected at the time of service unless other arrangements have been made. We accept cash, checks, and credit cards.

_____ _____

Patient 1/Parent 2/Guardian Signature Date

_____ _____

Signature of HHC Staff Date Date