HOMETOWN HEALTH CENTERS – PEDIATRIC PATIENT REGISTRATION

Patient Name: _____

Address: _____ Homeless □ Yes □ No

City: _____ State: _____ Zip Code: _____

Sex: M____ F _____ Date of Birth: _____

(For reporting purposes only)
Race: □ White □ Black/African-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: _____

HEAD OF HOUSEHOLD/PERSON RESPONSIBLE FOR THIS ACCOUNT

Name (mother/guardian/parent 1) _____ Mother's Maiden Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Relationship: _____ Marital Status: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

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

E-mail: _____ @ _____

Employer: _____

Name (father/guardian/parent 2) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Relationship: _____ Marital Status: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

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

E-mail: _____ @ _____

Employer: _____

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes □ Need custody papers 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

(If parents cannot be reached)

Name: _____ Phone #: _____

Address: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Insurance Subscriber Name: _____

Secondary Insurance: _____ ID#: _____

Insurance Subscriber Name: _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone number: _____

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.

_____ _____

Parent 1/Guardian Signature Date

_____ _____

Parent 2/Guardian Signature Date

_____ _____

Signature of HHC Staff Date