FAMILY MEDICAL CENTERS

PATIENT REGISTRATION INFORMATION FORM

Verified By:

DATE REC/ENTERED: _____

APPOINTMENT TYPE/STAFF USE ONLY ◯ Medical ◯ Dental ◯ Behavioral Health **STAFF INITIALS:** _____

- ☐ Aid Family Medical Center
- ☐ Chesapeake Family Medical Center
- ☐ Ironton Health Care Campus
- ☐ One-Stop Family Medical Center
- ☐ Proctorville Health Care Center
- ☐ South Point Family Medical Center
- ☐ Nancy's Place
- ☐ Rock Hill Family Medical Center

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY #:

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

MARITAL STATUS

◯ Single ◯ Widowed
◯ Married ◯ Civil Union
◯ Divorced

PREFERRED CONTACT METHOD

◯ Home Phone
◯ Cell Phone
◯ Work Phone
◯ E-Mail

HOME PHONE

CELL PHONE

WORK PHONE

E-MAIL ADDRESS

PRIMARY LANGUAGE ***(if not English)***

DO YOU NEED AN INTERPRETER? ◯ Yes ◯ No

GENDER INFORMATION

GENDER

◯ Male ◯ Female ◯ Transgender

IF TRANSGENDER

◯ Trans-Male to Female ◯ Trans-Female to Male

DO YOU THINK OF YOURSELF AS (Check all that apply)

◯ Straight/Heterosexual ◯ Don't Know
◯ Lesbian, Gay or Homosexual ◯ Something Else
◯ Bisexual

RACE INFORMATION

◯ Asian ◯ American Indian/Native American
◯ Alaskan Native ◯ Black/African American
◯ Native Hawaiian ◯ Pacific Islander
◯ White/Caucasian ◯ More Than One Race
◯ Unreported/Refused

ETHNICITY INFORMATION

◯ Hispanic/Latino ◯ Not Hispanic/Latino ◯ Not Reported

EMERGENCY CONTACT

Please give us the name of one person we can call if we cannot reach you and have important medical/dental information we need to inform you of immediately, (i.e., test results).

NAME	PHONE	RELATIONSHIP TO YOU	Does this person know you are an FMC patient?
			◯ Yes ◯ No

PHARMACY INFORMATION

NAME OF PATIENT'S FIRST CHOICE OF PHARMACY	PHARMACY ADDRESS

NAME OF PATIENT'S SECOND CHOICE OF PHARMACY	PHARMACY ADDRESS

ADDITIONAL PARENT/GUARDIAN INFORMATION

NAME	PHONE	Street Address	City, State, Zip

NAME	PHONE	Street Address	City, State, Zip

HOUSING STATUS

ARE YOU HOMELESS? ◯ Yes ◯ No **IF SO, ARE YOU:** ◯ Doubled-Up (Living with others) ◯ Shelter ◯ Street ◯ Transitional

INCOME INFORMATION

In order for Family Medical Centers to help our patients, we must ask **everyone** to complete the following information. This is requested of you so that FMC can receive Federal grant dollars to serve our patients. We appreciate your cooperation. All information is kept confidential and is used for reporting purposes only.

Total number of people in your household, including yourself: _____

Total household income: *(Please check the amount that best describes the total income in your household.)*

◯ Less than $11,000
◯ $11,001-$15,000
◯ $15,001-$20,000
◯ $20,001-$25,000
◯ $25,001-$30,000
◯ $30,001-$35,000
◯ $35,001-$40,000
◯ $40,001-$45,000
◯ $45,001-$50,000
◯ $50,001-$55,000
◯ $55,001-$60,000
◯ $60,001-$65,000
◯ $65,001-$70,000
◯ $70,001-$75,000
◯ Greater than $75,000

RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY #:	HOME PHONE

STREET ADDRESS	DATE OF BIRTH (MM/DD/YYYY)	CELL PHONE

CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	WORK PHONE

EMPLOYMENT INFORMATION

◯ Employed ◯ Retired ◯ Disabled ◯ Full-Time Student
◯ Unemployed ◯ Other ◯ Military (National Guard or Veteran) ◯ Part-Time Student

iF EMPLOYED:

NAME OF EMPLOYER: _____ ◯ Full-Time ◯ Part-Time ◯ Self-Employed

ADDRESS OF EMPLOYER: _____ CITY: _____ STATE: _____ ZIP: _____

VETERAN/MILITARY INFORMATION

Is or was the patient ever a member of the US MILITARY or is the patient an US VETERAN? ◯ Yes ◯ No

AUTHORIZATION & RELEASE

VERIFICATION OF INFORMATION *(Must be signed before submitting)*

I authorize my insurance benefits be paid directly to the Family Medical Centers. I understand that I may be responsible for non-covered charges. I also authorize the Family Medical Centers to release any information required to process this claim. Furthermore, I authorize any information regarding my care to be shared between all the Family Medical Centers and Behavioral Health-Psychiatry. I also authorize Family Medical Centers providers to access my prescription history so they can check for possible drug interactions or avoid prescribing medications you may be allergic to.

SIGNATURE: _____ DATE: _____