UNITED COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM – Please complete front and back of this form

Last Name: ______________________________________ First Name:_________________________________

SS #: _____________________________________ Date of Birth: ________________________ Sex: M F

Patient Address: ____________________________________Apt #____________ PO Box___________

City:_________________________________ State ________Zip Code ___________ County____________

Patient Phone: __________________________ Alternate Phone: ___________________________________

Emergency Contact Name: ___________________________ Phone #: ________________________

Relationship to you: ____

Do you need the assistance of an interpreter? Yes No Language: ______________________

Person Responsible for bill:
Name: ____

Relationship of Patient to responsible party: Child Spouse Self

Date of Birth: ______________________________ SS#: ___________________________________

Gender: M F Home Phone: ______________________ Work Phone: ______________________

Address: ______________________________________City_________________________State ___________

Employer: _____________________________________Employer Phone: _______________________________

Medical Insurance Information
Do you have medical insurance? Y N If yes, please provide copy of insurance card.

Name of your insurance company: ____

Name and Birthdate of Insurance Card holder (If different than responsible party listed above)

Name ____________________________________ Date of birth ___________________________________

Relationship of Patient to Card Holder Self Spouse Dependent (circle one)

How did you hear about us? ____

Preferred Pharmacy: ____

Please continue on back of this form

Patient Income & the Sliding Fee Schedule

Number of persons your household	Weekly Gross Income maximum
1	$392.00
2	$526.00
3	$660.00
4	$794.00
5	$928.00
6	$1,062.00

If your household size and gross weekly income **falls at or below these guidelines** you can qualify for our Sliding Fee Schedule. Documentation required.

Even if you have medical insurance you can participate in our discounted fee schedule to assist in covering the costs of deductibles, labs and procedures your insurance will not pay.

☐ Yes, I would like to complete the application for discounted fees and the Sliding Fee Schedule.

☐ No, I am not interested or I do not qualify for the discounted fees and the Sliding Fee Schedule.

Household weekly income $______________# of children at home________ # of adults at home _________

Income source(s): ____
You will be required to provide 1 month (4 weeks) of pay stubs **or** a copy of your Federal Income Tax Return

List others who you claim on your Federal Tax Return – this information is required

Dependent Name	Dependent Age	Dependent date of birth	Relationship to You

Marital Status	☐Single ☐Married ☐Divorced ☐Widowed
Student Status	☐FT ☐PT ☐Not in school
Employment Status	☐FT ☐PT ☐Not employed
Race	☐Amer. Indian ☐Asian ☐Black/Afr American ☐White
	☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander
Housing Status	☐Street ☐Doubling Up ☐Homeless Shelter ☐Transitional
	☐Not Homeless ☐Other ☐Unknown
Agricultural Status	☐Not agricultural worker ☐Dependent of migrant worker
	☐Dependent of seasonal worker ☐Migrant Worker
	☐Seasonal worker

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Payment Agreement: I hereby certify that the above information is true and that I have reported all sources of income being received to support my family. I agree to promptly and fully pay any charges for services and supplied by United Community Health Center according to the fees established.

Assignment of Benefits: I hereby assign and authorize direct payment to United Community Health Center of all insurance coverage or other benefits under any government program, any insurance policy or plan, or any other available benefit. This assignment shall remain in effect until revoked in writing.

Consent to Medical Treatment: I hereby request and give consent for the health care professionals at United Community Health Center to provide medical treatment to me and/or my family.

Consent to Release Protected Health Information: I authorize United Community Health Center to release medication information relating to the patient to health insurance companies, health plans or third party payors, or their authorized agents, for the purpose of determining benefits payable in connection with services provided.

_______________________________________ ___________________________

Patient or Responsible Party Signature Date