



Registration Form

Please Print Clearly

New Patient Established Patient

Today's Date: ___/___/___

Patient Information

Last Name: _____ First Name: _____ MI: _____

Other/Maiden/AKA Name: _____

Birth date: _____ Social Security #: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell or Work Phone: _____

Marital Status: Single _____ Married _____ Sex: Male _____ Female _____

Race: Caucasian (White) _____ Afro-American (Black) _____ American Indian/Alaska Native _____ Asian _____
Native Hawaiian _____ Pacific Islander (other than Hawaiian) _____
Whites of Latino/Hispanic descent _____ Blacks of Latino/Hispanic descent _____
American Indian of Latino/Hispanic Descent _____ More than One Race _____ Refuse to Report _____

Are you a veteran of the United States Armed Forces? Yes No

Responsible Party

Name: _____ Home Phone #: _____

Social Security #: _____ Relationship to Patient: _____

Address: _____ Birth date: _____

Drivers License #: _____ State Issued: _____
(or other government issued ID)

Insurance Information

Do you have insurance? Yes No
If Yes, please specify: Medicare Medicaid CHIP Private Insurance

Primary Insurance Company _____

Secondary Insurance Company _____

SEE OTHER SIDE

Siding Fee Discount For Service

I understand that in order to receive the federal sliding fee discount for services at Southwest Utah Community Health Center, I must provide proof of income for all wage earners in my household. I understand that all sources of income, including wages, unemployment, social security, retirement, alimony, child support and disability income will be included. I understand that proof of income is required and can include check stubs, letters from employers, statement from person(s) providing your support, copies of income tax information and/or documents from government services. If I do not provide proof of income now, **I must bring my income proof to Southwest Utah Community Health Center within 7 days.** I also understand that my eligibility to receive medical care at a reduced rate will be reviewed every 6 months.

I understand that proof of income allows me to receive discounted services. I know that I will pay a co-pay for each visit and may be charged more depending on the services received.

I understand that if I have insurance, the Community Health Center may be able to discount services that are not covered by my insurance policy with proof of income.

Signature _____ Date _____

Payment is due at the time of service. Please read and sign the following:

Financial Agreement and Release of Information _____ (Initial)

I authorize Southwest Utah Community Health Center to bill my insurance carrier for services rendered. I also authorize Southwest Utah Community Health Center to release all or part of the patient's record to any person or organization liable for payment. I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of medical insurance benefits be paid to Southwest Utah Community Health Center. **I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney's fees.**

Consent for Treatment _____ (Initial)

I authorize the Southwest Utah Community Health Center licensed healthcare provider to perform such diagnostic, medical, and/or surgical procedures as may be necessary for proper health care. I also give permission for administration of medications and immunizations as may be necessary for that treatment.

I have read all of the information on this registration form and have completed it to the best of my ability. I certify that this information is true and correct to the best of my knowledge. I understand that proof of the above information may be required at any time for any reason. If found ineligible, I may be subject to immediate termination of services and/or prosecution for fraud/perjury. I will notify Southwest Utah Community Health Center of any changes in my health status or any of the above information.

Patient's Signature (If a minor, signature of responsible party) Relationship Date

Witnessed By: _____ Date: _____

**SOUTHWEST UTAH COMMUNITY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES**

Acknowledgment of Receipt

Effective Date: April 14, 2003

Please review the Notice of Privacy Practices carefully.

The Notice of Privacy Practices tells you how Southwest Utah Community Health Center (SWUCHC) may use or disclose information about you. Not all situations will be described. SWUCHC is required to inform you of our privacy practices for the information we collect and keep about you.

I, _____ (patient's name) have been given a copy of SWUCHC's Notice of Privacy Practices and have had a chance to ask questions about how my information should be used.

OPTIONAL DISCLOSURE:

I hereby authorize Southwest Utah Community Health Center to disclose and:

_____ **Send** my confidential health care information **to** the addressee below:

_____ **Receive** my confidential health care information **from** the addressee below:

_____ **Authorize** : _____ (name of person such as your husband, wife, parent)
access to my records either verbally or written for a period of six months from date entered below.

Patient's Signature

Date

Legal or Personal Representative of Patient (if applicable)

Date

Patient's Name: _____
Date of Birth: _____

Today's Date: _____
Chart #: _____

Family History

Has any member of your family had any of the following illnesses (indicate who):

- Asthma _____ Blood Disorder _____ Thyroid Problems _____
- Stroke _____ Hypertension _____ Heart Problems _____
- Cancer _____ Seizures _____ Mental Health (Specify) _____
- Diabetes _____ Other (Specify) _____

Past Medical History

Previous Physician's Name: _____ Date of last exam: _____

Which of the following conditions are you currently being treated or have been treated for in the past? (please check):

- Asthma Thyroid Problems Pain (Specify: _____)
- Blood Disorder Hypertension Heart Problems (Specify: _____)
- Cancer Seizures Mental Health (Specify: _____)
- Diabetes Stroke Other (Specify: _____)

Please list all current medications:

Name: _____ Strength: _____ Frequency: _____
For: _____

Name: _____ Strength: _____ Frequency: _____
For: _____

Name: _____ Strength: _____ Frequency: _____
For: _____

Name: _____ Strength: _____ Frequency: _____
For: _____

(Continue on back side, if necessary.)

Allergies:

Do you have any allergies (please check)? Penicillin Latex Other (Specify: _____) None

Please list all past surgeries:

Surgery: _____ Date: _____ Surgery: _____ Date: _____
Surgery: _____ Date: _____ Surgery: _____ Date: _____

(Continue on back side, if necessary.)

Social and Preventative History:

Do you currently smoke or chew tobacco? Yes No If no, have you in the past? Yes No
Are you exposed to smoke in the home? Yes No If no, have you been in the past? Yes No
Do you drink alcohol? Yes No If no, have you in the past? Yes No
Do you use illegal drugs? Yes No If no, have you in the past? Yes No
Have you been exposed to STDs? Yes No

Learning Needs Assessment:

May we leave detailed messages on your phone? Yes No
Do you speak English in your home? Yes No If no, what language do you speak? _____
Do you see well? Yes No If no, do you use glasses or contacts? Yes No
Do you hear well? Yes No If no, do you use a hearing device? Yes No
Do you have any cultural or religious practices or beliefs that may affect your care or treatment? Yes No
If yes, please specify: _____

How do you like to learn new things? (Check all that apply)

- Reading Discussion Video Demonstration / Hands-on Self study Other: _____