# PATIENT REGISTRATION FORM

**Please PRINT. Please return completed form(s) to Registration.**

## PATIENT INFORMATION

**MRN:** _____ **Date:** _____/_____/_____

**Name:** _____ **Legal Sex/Gender:** ☐ M ☐ F
FIRST MI LAST PREFERRED NAME

**Date of birth:** _____/_____/_____ **Social Security No.:** _____-_____-_____

**Street Address:** _____ **PO BOX:** _____

**City:** _____ **State:** _____ **Zip Code** _____

**County:** _____ **Email:** _____

**Home/Mobile Phone:** _____ **Work Phone:** _____

**Emergency Contact Name:** _____ **Relationship:** _____

**Emergency Phone #:** _____ **Primary Language:** ☐ English ☐ Spanish ☐ Other _____

**Religion:** _____ **Are Interpreter Services needed?** ☐ YES ☐ NO

**Race:** ☐ American Indian/Alaska Native ☐ Black or African American ☐ Caucasian/White ☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan ☐ Guamanian or Chamorro

**Ethnicity** ☐ Hispanic ☐ Non-Hispanic

**Employed** ☐ Full ☐Part time ☐ Unemployed

**Student** ☐ Full ☐ Part time

**Status:** ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

**Are you a veteran?** ☐ YES ☐ NO

**Are you a farmworker?** ☐ YES ☐ NO

**Are you a student?** ☐ YES ☐ NO

**Are you homeless?** ☐ YES ☐ NO

**Public Housing?** ☐ NO YES ☐ ☐ Stable ☐ Temp ☐ Unstable

**Special Needs?** ☐ Bariatric ☐ Hearing Impaired ☐ Risk of fall ☐ Short Stature ☐ Speech Impaired ☐ Visually Impaired ☐ Wheelchair ☐ None

**Number of persons in Household: Adults:** _____ **Children:** _____

## RESPONSIBLE PARTY INFORMATION
***(Complete this section if Responsible Party is NOT the Patient)***

**Relationship of Responsible Party:** ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other _____

**Name:** _____ **Legal Sex/Gender:** ☐ M ☐ F
FIRST MI LAST

**Date of birth:** _____/_____/_____ **Social Security No.:** _____-_____-_____

**Street Address:** _____ **PO BOX:** _____

**City:** _____ **State:** _____ **Zip Code** _____

**Home Phone:** _____ **Work Phone** _____

**Employer:** _____

## INSURANCE INFORMATION

***Please present your insurance card to the Intake each time you check-in***

**MRN:** _____

**PRIMARY INSURANCE**

**Plan Name:** _____ **ID Number:** _____

**Address:** _____ **Group Number:** _____

**Policy Holder:** _____ **Effective Date:** _____

**Policy Holder's Social Security No.**: _____-_____-_____ **Sex:** M ☐ F ☐

**Policy Holder's Date of birth**: _____/_____/_____

**Employer:** _____

**SECONDARY INSURANCE**

**Plan Name:** _____ **ID Number:** _____

**Address:** _____ **Group Number:** _____

**Policy Holder:** _____ **Effective Date:** _____

**Policy Holder's Social Security No.**: _____-_____-_____ **Sex:** M ☐ F ☐

**Policy Holder's Date of birth**: _____/_____/ _____

LCHC requires payment on the day of service. This payment includes outstanding deductibles, co-payments, non-covered services, sliding fee payments and any charges remaining after insurance has made payment on your account. Please be advised that your insurance may not cover all of your charges and that you are responsible for any balance on your account and will be billed until that balance is paid. The Sliding Fee Program is for families with low incomes. This program allows patients to get a discount on the charges. You must apply with registration staff with verification of the total income and number of persons in the household. You must reapply for the program every year and payment must be made at time of service. Signing of this form indicates you are aware of above policies and procedures and were advised of the sliding fee program. I hereby authorize assignment of all insurance benefits payable directly to LCHC.

**Signed**: _____ **Date**: _____/_____/_____

**FOR INTERNAL USE ONLY**

**LCHC Employee Signature**: _____

**Assigned PCP**: _____