Salud Family Health

Patient Registration Form

As a Federally Qualified Health Center, we are required to request some personal information about you. All information provided will be kept confidential.

Please fill out the following information to register for our services.

First Name: ____________________ **Middle Initial**: _________ **Last Name**: __________________________

Name I go by: ____

Address: ____

City: ____**State**: _________ **Zip Code**: ____________

Preferred Phone: ☐Home ☐Cell **Home Phone**: ___________________ **Cell Phone**: __________________

Email address: ____
(for access to patient portal for adults and minors 12 years and younger)

DOB:____________ **Social Security Number**:_________________ **Language Preference**: ________________

What was your sex assigned at birth? ☐Female ☐Male ☐Unknown

What is your gender identity?: ☐Female ☐Male ☐Genderqueer/Non-conforming ☐Other: __________

☐Transgender man (female to male) ☐Transgender woman (male to female) ☐Choose not to disclose

Are you currently homeless? ☐Yes ☐No **Are you a veteran?** ☐Yes ☐No

Do you live in public housing (i.e., Section 8, a half-way house, a homeless shelter)? ☐Yes ☐No

Employment Status: ☐Full time ☐Part-time ☐Not employed ☐Self-employed ☐Retired ☐Active Military ☐Reserved for National Assignment

Marital Status: ☐Single ☐Married ☐Partner ☐Divorced ☐Widowed ☐Legally Separated ☐Unknown

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Declined to Specify

Do you have any of the following? ☐ Advanced Directive* ☐Power of Attorney ☐None
**An Advanced Directive is a legal document that explains your wishes for your medical treatment if you are unable to communicate your desires (for example a living will).*

Do you have health coverage? ☐Yes ☐No

Name of insurance *(please provide a copy of insurance card)*: ______________________________________

Insurance Holder's Name: ____

Salud Family Health receives special funding to provide discounted services to certain patient populations. Please answer the following questions:

1. At any time in the past two years, have you or anyone in your family had a job working with or transporting plants, trees, or farm animals? ☐Yes ☐No
2. If so, to do that work, have you had to establish a temporary home? ☐Yes ☐No
3. At any time did you or anyone in your family retire from a job working with or transporting plants, trees, or farm animals? Yes No

As a Federally Qualified Health Center, Salud is required to ask about household income and family size.
What is your estimated household income before taxes?
Monthly:________________ or Annual:__________________

How many financial dependents are in your household (including yourself and your spouse)?____________

What is your preferred pharmacy? ☐ Salud Pharmacy **Other Pharmacy**:___________________________
Pharmacy Address:____

List an emergency contact in the event of an emergency. This does not grant them access to your health information.

Emergency Contact Name:___________________________________ Relationship:____________________

Phone Number:____

Optional: Health Information Access - If there is anyone else with whom you would like to share your health information, you may designate that person below.

We will share your health information as needed with this person. We may call, text, or leave voice messages at their specified phone number. We will also answer questions they may contact us with.

I give permission for my protected health information to be disclosed to the person listed below:

Name:____ Relationship:____________________________

Address:____

Phone number:____

Electronic Consents - The phone numbers you provided will be used to message you via text and/or voice about appointment reminders and to reach you about results or telehealth visits. It is your responsibility to maintain your contact information current with us so we may reach you. If you would like to receive communications via alternative means or at alternative locations, please advise a Salud staff member. Salud participates in electronic health information exchanges to share your health information with other health care providers when relevant to your care, such as for hospitals visits. You have the option of opting out of this health information exchange if you choose.

Do you want to opt out of having your health information shared in any health information exchange?
☐ Yes - Opt out ☐ No - Allow information exchange

The following documents provide information regarding your care at Salud Family Health. Your initials and signature below indicate that you have received a copy of each document, understand the information, and agree to the terms and conditions outlined.

_______ **Consent for Treatment** - This document allows you and any family members 17 and younger to which you are a parent or legal guardian to receive medical, behavioral health and dental treatment at Salud Family Health Center.

_______ **Patient Rights and Responsibilities** - This document explains your rights and responsibilities as a Salud patient, including your right to be treated with respect and dignity and your responsibility to be considerate and respectful towards Salud's health care team.

_______ **Salud is Your Medical Home** - This document explains what it means to be a Medical Home, including using a team-based approach to patient care and empowering you to be responsible for your own health care.

_______ **Patient Financial Rights and Responsibilities** - This document provides details on how Salud collects fees for the services we provide, including the expectation for you to make a payment for your portion of fees before services are delivered.

_______ **Missed and Late Appointment Policy** - This document provides details on the consequences of arriving more than fifteen minutes late for an appointment or not calling to cancel your appointment by 4pm the day prior to your scheduled appointment if you need to reschedule or cancel it.

_______ **HIPAA Notice of Private Practices** - This notice provides information on how we keep your information private and ways we may share your healthcare information.

Print Name:____**Date**:____________________

Signature:____

(Your signature authorizes care for you and any minor(s) you have listed on this registration form)