Scenic Bluffs
COMMUNITY HEALTH CENTERS

PATIENT REGISTRATION FORM – PLEASE PRINT

First Name: _____ **MI**: _____**Last Name**: _____

Has patient ever used a different last name? ❑ Yes ❑ No ***If yes, what name?** _____

Street Address_____

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

Primary Phone: ❑ Home ❑ Work ❑ Cell # _____

Secondary Phone: ❑ Home ❑ Work ❑ Cell #_____

Who is your Primary Medical Care Provider?

❑ Scenic Bluffs Provider_____

❑ Other _____

Name of Medical Clinic _____

Who is your Primary Dental Care Provider?

❑ Scenic Bluffs Provider_____

❑ Other _____

Name of Dental Clinic _____

Date of Birth: _____/_____/_____

Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Other ❑ Choose not to disclose

Patient is: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Social Security#:_____-_____-_____ ❑ none

Is patient employed? ❑ Yes ❑ No

Employer's Business Name: _____

Employer's Address, City, State, Zip_____

Phone#:_____

Is patient a student? ❑ YES ❑ NO
If yes: ❑ Full-time ❑ Part-time

BILLING INFORMATION- **Who is financially responsible for paying patient's bill?** ❑ Patient ❑ Other

If person responsible for bill(s) is different than patient: → *fill in below* ↓

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Step Mother ❑ Step Father ❑ Guardian ❑ Foster Parent ❑ POA

First: _____ MI: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Telephone #:_____

CONTINUED ON REVERSE SIDE →

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Employer's Business Name: _____ Telephone #: _____

Employer's Address, City, State, Zip: _____

Is the patient covered by insurance? ❑ Yes ❑ No **Please present insurance cards to front desk staff.**
Without accurate insurance information, Scenic Bluffs is unable to accurately submit claims on your behalf and you, or person financially responsible for paying the patient's bill, will be issued a statement for the costs for all services provided at patient's visit. If you do not have health insurance, we offer a sliding fee scale called the Health Neighbor Plan.

We offer a Sliding Fee Program- the Healthy Neighbor Plan- to those who qualify. Fill out the application provided to enroll. ❑ Already Enrolled

Email address: _____

Race: ❑ White ❑ Asian ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Other_____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

What language is patient best served in? ❑ English ❑ Spanish ❑ Other_____

Which Pharmacy do you use?
❑ Scenic Bluffs Pharmacy
❑ Other- List Name/Location of Pharmacy_____

Do you understand English? ❑ YES ❑ NO
If no: Do you require a translator? ❑ YES ❑ NO
If no: What language other than English do you understand? _____

Is patient a Veteran? ❑ YES ❑ NO

Is patient Amish? ❑ YES ❑ NO

Is patient Homeless? ❑ YES ❑ NO

Public Housing? ❑ YES ❑ NO

Special Needs: ❑ YES ❑ NO
If yes, please select: ❑ Vision Impairment ❑ Hearing Impairment ❑ Cognitive Issues ❑ Other

Sexual Identity: ❑ Straight ❑ Lesbian or gay ❑ Bisexual ❑ Something else ❑ Don't know ❑ Choose not to disclose

Is someone other than patient responsible for healthcare decisions? ❑ YES → *if yes fill in below* ↓

Are you related to the patient? ❑ YES ❑ NO Relationship? _____

Are you a Foster Parent/Legal Guardian? ❑ YES ❑ NO If guardian, please provide documentation.

Parent/Guardian Full Name: _____ Date of Birth: _____/_____/_____

Street Address: _____

City: _____State:_____ Zip: _____ Telephone #:_____

Any other parent/legal guardian? ❑ YES ❑ NO **Relationship?** _____

Parent/Guardian Full Name: _____ Date of Birth: _____/_____/_____

Street Address (if different than above): _____

City: _____ State: _____ Zip: _____ Telephone #:_____