PATIENT REGISTRATION FORM

As a Federally Qualified Health Center, we are required to collect some personal information for statistical purposes only. No individual information is submitted. Your cooperation helps us improve healthcare for all. Terry Reilly Health Services does not discriminate in its services, treatment, program, activities, or employment regardless of race, color, religion, national origin, age, physical or mental disability, veteran status, or sex, including gender identify and sexual orientation.

PATIENT NAME

First | Last | MI | Date of Birth (/ /)

Preferred Name | Social Security Number | ☐ Male ☐ Female (Sex at birth) | Home phone

Home Address | City | State | Zip | Mobile phone ☐ OK to Text/Leave Message

Mailing Address (if different from home address) | City | State | Zip | Email | ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Temp

Employer -Patient | Employer Address | Employer phone | Employment Status

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Partner

ETHNICITY ☐ Not Hispanic/ Latino ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/ Latino or Spanish Origin

RACE ☐ White ☐ Black/ African American ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Alaska Native ☐ American Indian ☐ Native Hawaiian ☐ Guamanian, Chamorro ☐ Other Pacific Islander

GENDER IDENTITY ☐ Male ☐ Female Transgender: ☐ Male/ Female to Male ☐ Female/ Male to Female ☐ Other ☐ Choose not to disclose ☐ Unknown

PATIENT'S PRONOUNS ☐ He/ Him/ His ☐ She/ Her/ Hers ☐ They/ Them/ Theirs ☐ Patient's name ☐ Decline to answer ☐ Unknown

SEXUAL ORIENTATION ☐ Straight/ Heterosexual ☐ Lesbian/ Gay ☐ Bisexual ☐ Other ☐ Don't Know ☐ Choose not to disclose

US VETERAN MILITARY STATUS ☐ Active ☐ Inactive ☐ Reservist ☐ Veteran ☐ None

PRIMARY MEDICAL CARE PROVIDER

Name of Medical Provider | Name of Facility | Phone #

EMERGENCY CONTACT INFORMATION

Name | ☐ Spouse ☐ Parent ☐ Other: (Relationship to patient) | Primary phone:

LANGUAGE

In what language can we best meet your healthcare needs (including sign language)? _____

Will you need an interpreter? ☐ Yes ☐ No

How comfortable are you reading instructions, pamphlets, or other written material from your doctor or pharmacy?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Extremely

PARENT/GUARDIAN INFORMATION

Name | ☐ Parent ☐ Other (Relationship to patient) | Date of Birth (/ /)

Social Security # | Mobile phone ☐ OK to Text/Leave Message | Home phone | Email | ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Temp

Address | City | State | Zip | Employment Status

Employer - Parent/Guardian | Employer Address | Employer Phone

FARMWORKERS in the past two years:

Have you or a family member worked in Agriculture (fields, orchards, etc.) as a primary source of your income? ☐ Yes ☐ No

If yes, does this person change residence as a part of his work? ☐ Yes ☐ No

Have you or a family member stopped migrating to work in Agriculture due to disability or old age? ☐Yes ☐ No

HOUSING STATUS

Do you own or rent your home? ☐ Yes ☐ No -If no, how would you describe your housing arrangement today?
☐ Permanent Supportive Housing (New Path, CHOIS) ☐ Single Occupancy Hotel
☐ Temporarily living -Relative/Friends How long? _____
☐ US Veteran at risk of homelessness ☐ Child at risk of homelessness
Temporarily living in: ☐ Street/ Car/ Camping ☐ Shelter ☐ Homeless Transitional Housing
☐ Other Please describe _____

HOUSEHOLD WAGES AND INCOME

Include all sources of income -wages, social security, unemployment, assets, pension, and child support

Total household income before taxes: $_____ ☐ Hourly _____ ☐ Monthly ☐ Yearly
Hours per week

How many family members live in your household; include parents, and children. (Exclude extended family) _____

Please list patient, parent, spouse and children	Date of Birth		Date of Birth
	/ /		/ /
	/ /		/ /
	/ /		/ /

I understand my verification of income may be audited for accuracy and I agree to provide all records as requested.
I give Terry Reilly my permission to share my information with other organizations, grantors, or providers (and their auditors) that provide discounted services to me at the request of Terry Reilly. Example of such organizations are laboratories, medical imaging services, or medical specialists, etc.

INSURANCE INFORMATION (Please list all Medical and Dental Coverage)

☐ **Check if No Insurance**

Medical Insurance Name	Medical Insurance Name	Dental Insurance Name
Policy # / Group #	Policy # / Group #	Policy # / Group #
Subscriber Name	Subscriber Name	Subscriber Name
/ /	/ /	/ /
Subscriber Date of Birth:	Subscriber Date of	Subscriber Date of
☐ Self ☐ Spouse ☐ Parent	☐ Self ☐ Spouse ☐ Parent	☐ Self ☐ Spouse ☐ Parent
Subscriber Name	Relationship to patient	Relationship to patient

ACKNOWLEDGEMENTS

Patient Rights and Responsibilities I have been given access to, and may have a copy of, the Terry Reilly Patient Rights and Responsibilities.
Notice of Privacy Practices: I have been given access to, and may have a copy of, the Terry Reilly Notice of Privacy Practices.
Health Information: I understand that my health information may be shared across the Terry Reilly dental, medical and behavioral health divisions.
Idaho Health Data Exchange (IDHE): I understand that Terry Reilly is a member of the IHDE, a secure internet-based health information exchange for improving quality coordination of health care in Idaho. I understand I may "opt out" from the IHDE by completing a Requests to Restrict Disclosure of Health Information and submitting it directly to IHDE by mail or fax or am able to contact IHDE at (208) 803-0030.
Partner Data Access Program (PDAP): Terry Reilly Health Services may access my information from the Idaho Department of Health and Welfare Partner Data Access Program (PDAP) to determine my eligibility for discounts on healthcare.

Terry Reilly Health Services *is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a business associate of Adapt Oregon OCHIN supplies information technology and related services to* ***Terry Reilly Health Services*** *and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by* ***Terry Reilly Health Services*** *with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive. The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.*

I certify the information provided here is true, complete, and accurate. I understand intentionally providing false information may exclude me from services at Terry Reilly. I will promptly notify Terry Reilly of changes in insurance, family income or size.

Patient Signature _____ Date _____

Parent/Guardian Name (Please Print) _____ Parent/Guardian Signature _____ Date _____