TERRY REILLY
Your Health. Our Mission.

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 REGISTRATION FORM

PATIENT INFORMATION			
First Name:	Middle Name:	Last Name:	
Preferred Name:			
Birth Date:	Gender at birth:	Social Security #:	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Partner			
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)			
Name:			
Birth Date:	Gender:	Social Security #:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:		Relationship to Patient:	

RESPONSIBLE PARTY'S EMPLOYER INFORMATION	
Check one: ☐ Part Time ☐ Full Time ☐ Self-Employed ☐ Unemployed ☐ Retired	
Employer Name:	
Employer Address:	Employer Phone:

☐ **No Health Insurance** INSURANCE INFORMATION		
Primary Medical Insurance:		Policy Number:
Insured Party Name:		Group Number:
Insured Party Birth Date:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent	
Secondary Medical Insurance:		Policy Number:
Insured Party Name:		Group Number:
Insured Party Birth Date:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent	
Dental Insurance:		Policy Number:
Insured Party Name:		Group Number:
Insured Party Birth Date:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent	

EMERGENCY CONTACT INFORMATION	
Name:	Phone:
Address:	Relationship to Patient:

As a Federally Qualified Health Center, we are <u>required</u> to collect the following information for statistical purposes only. No individual information is submitted. Your cooperation helps us improve healthcare for all.

Sexual Orientation	☐ Straight ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Other ☐ Unknown ☐ Choose not to disclose		
Gender Identity	☐ Male ☐ Female ☐ Transgender (Male/Female to Male) ☐ Transgender (Female/Male to Female) ☐ Other ☐ Unknown ☐ Choose not to disclose		
Ethnicity	Are you Hispanic/Latino?	☐ Yes	☐ No

Race	☐White ☐Black/African American ☐Asian ☐Hawaiian Native ☐Pacific Islander ☐ American Indian/Alaska Native ☐ Other		
Language	In what language can we best meet your healthcare needs (including sign language)? _____		
Veterans	Are you a Veteran?	☐ Yes	☐ No
Farmworkers	**In the past two years**, have you or a member of your family worked in Agriculture (fields, orchards, etc.) as the primary source of income?	☐ Yes	☐ No
	If yes, does this person change residence as part of his work?	☐ Yes	☐ No
	Have you or a member of your family stopped migrating to work in Agriculture due disability or old age?	☐ Yes	☐ No
Family Income	Our annual household income before taxes is $_____. There are _____ people in my household including myself.		
	Check here if you decline to provide income information: ☐		

HEALTHCARE FOR THE HOMELESS
If you do not own a home or rent, how would you describe your living arrangements?
I am temporarily living in: ☐ Shelter ☐ Transitional Housing ☐ Street/Car/Camping ☐ Drug Treatment Center ☐ Friends/Relative - How long? _____ ☐ Other (Explain or describe) _____

BOISE CLINIC PATIENTS ONLY
Are you a single mother with children 17 years or younger living with her? ☐ Yes ☐ No
Do you live in Boise City Limits? ☐ Yes ☐ No
Does anyone in your household have a disability? ☐ Yes ☐No If yes, how many people?
CDBG: FOR STAFF USE ONLY (REQUIRED) Date: # of Children:
☐ CDBG Eligible ☐ CDBG Ineligible Staff Cert Initials:

Terry Reilly receives grant funding from multiple sources including Community Development Block Grant, Council on Domestic Violence, and United Way. Statistical information collected is voluntary and is not a condition for receiving services.

ACKNOWLEDGEMENTS
Accuracy and Truthfulness of Information: The information I have provided is complete and accurate. I understand intentionally providing false information may exclude me from services at Terry Reilly, and I may be billed for discounts received under false pretenses.
Patient Rights and Responsibilities/Notice of Privacy Practices: I have been given access to, and may have a copy of, the Terry Reilly Patient Rights and Responsibilities and Notice of Privacy Practices. If I believe these rights have been violated, I may file a complaint.
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 (IHDE): I understand that Terry Reilly is a member of the IHDE, a secure internet-based health information exchange for improving quality and coordination of health care in Idaho. I understand I may "opt out" from the IHDE by completing a Request to Restrict Disclosure of Health Information and submitting it directly to IHDE by mail or fax or am able to contact the IHDE at (208) 332-7253.
Patient/Representative Signature_____ Date _____ If Representative, Relationship to Patient: _____