# 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 (Please print)

First ______ Last ______ MI ______ Date of Birth ___/___/___

Preferred Name ______ Social Security Number ______ ☐ Male ☐ Female (Gender at birth)

## CONTACT INFORMATION (Check preferred contact method)

Mailing Address ______ City ______ State ______ Zip ______

☐ Email address ______ ☐ Mobile phone ☐ OK to Text? ______ ☐ Home phone ______

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

**ETHNICITY** Are you Hispanic/ Latino ☐ Yes ☐ No

**RACE** ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Hawaiian Native ☐ Pacific Islander ☐ Other

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

**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 ☐ Unknown ☐ Choose not to disclose

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

## PRIMARY CARE PROVIDER

Name ______ Phone # ______

## EMERGENCY CONTACT INFORMATION

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

Email ______ Secondary Phone # ______

## EMPLOYMENT INFORMATION- PATIENT

(Check one) ☐Full Time ☐ Part Time ☐ Unemployed ☐ Temp

Employer Name ______ Employer Phone ______ Employer Address ______

## LANGUAGE

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

Will you need an interpreter? ☐ Yes ☐ No

## PARENT/GUARDIAN INFORMATION

Name ______ ☐ Parent ☐ Other: ______ (Relationship to patient) Date of Birth ___/___/___

Social Security #: ______ Phone #: ______

Address ______ City ______ State ______ Zip ______

Employer - Parent/Guardian ______ Employer Phone # ______ ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Temp Employment Status (Check one)

## 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 ☐ Temporarily living with Relative/ Friends- How Long? ______

Temporarily living in: ☐ Street/ Car/ Camping ☐ Shelter or ☐ Transitional Housing ☐ Other ______

## HOUSEHOLD WAGES AND INCOME

☐ I do not wish to provide this information

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

(Includes all sources of income wages, social security unemployment, assets, pension, child support)

Total family members in your household: ____________
(Count each member living in your household, including parents, children, but not extended family members.)

**Would you like to use this information to apply for our sliding fee discount program? ☐ Yes ☐ No**

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)

| **Medical Insurance Name** | Policy # | Group # |
|---|---|---|
| Subscriber Name | Date of Birth: | ☐ Self ☐ Spouse ☐ Parent<br>Relationship to patient |
| **Medical Insurance Name** | Policy # | Group # |
| Subscriber Name | Date of Birth: | ☐ Self ☐ Spouse ☐ Parent<br>Relationship to patient |
| **Dental Insurance Name** | Policy # | Group # |
| Subscriber Name | Date of Birth: | ☐ Self ☐ Spouse ☐ Parent<br>Relationship to patient |
| **Dental Insurance Name** | Policy # | Group # |
| Subscriber Name | Date of Birth: | ☐ Self ☐ Spouse ☐ Parent<br>Relationship to patient |

☐ Check if No Insurance

## ACKNOWEGEMENTS

**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 pretense.

**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) 332-7253.

**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.

Receipt of family planning services is not a prerequisite to receive of any other services offered.

***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 will promptly notify Terry Reilly of charges in insurance, family income or size.**

**Patient Signature** ____________ **Date** ____________

**Patient/Guardian Name** (Please Print) ____________

**Patient/Guardian Signature** ____________ **Date** ____________