



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 (Check preferred contact method)

First	Last	MI	Date of Birth
			<input type="checkbox"/> Male <input type="checkbox"/> Female (Sex at birth)
Preferred Name	Social Security Number		
Home Address	City	State	Zip
Mailing Address (if different from home address)	City	State	Zip
<input type="checkbox"/> Mobile phone <input type="checkbox"/> OK to Text?	<input type="checkbox"/> Home phone	<input type="checkbox"/> Email address	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Temp
Employer -Patient	Employer Address	Employer phone	Employment Status (Check one)

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
 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

DOES ANYONE IN YOUR HOUSEHOLD HAVE A DISABILITY? Yes No

PRIMARY MEDICAL CARE PROVIDER

Name of Name 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

PARENT/GUARDIAN INFORMATION (Check preferred contact method)

Name Parent Other (Relationship to patient) Date of Birth

Social Security # Mobile phone OK to Text? Home phone Email Address

Address City State Zip Full Time Part Time
 Unemployed Temp

Employer - Parent/Guardian Employer Address Employer Phone # 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 (New Path, CHOIS) Single Occupancy Hotel Temporarily living with Relative/ Friends

US Veteran at risk of homelessness Child at risk of homelessness

How long?

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

Please describe

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

HOUSEHOLD WAGES AND INCOME

I do not wish to provide this information

Total household income before taxes: \$ _____ Hourly _____ Monthly Yearly

Hours per week

List number of family members living in your household; include parents, children, but not extended family members. _____

Patient/ Parent/ Guardian	Date of Birth / /	Spouse/ Parent/ Guardian	/ /
Child	Date of Birth / /	Child	Date of Birth / /
Child	Date of Birth / /	Child	Date of Birth / /
Child	Date of Birth / /	Child	Date of Birth / /

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)

Check if No Insurance

Medical Insurance Name	Policy #	Group #
Subscriber Name	Date of Birth:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent Relationship to patient
Medical Insurance Name	Policy #	Group #
Subscriber Name	Date of Birth:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent Relationship to patient
Dental Insurance Name	Policy #	Group #
Subscriber Name	Date of Birth:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent Relationship to patient

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 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 (IHDE): 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 changes in insurance, family income or size.

Patient Signature	Date
Patient/Guardian Name (Please Print)	
Patient/Guardian Signature	Date