Baptist Community Health Services, Inc.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last) (First) (Middle) (Jr, Sr, etc.)

Gender	**Social Security Number**	**Marital Status**	**Date of Birth**
☐Male ☐Female		☐Single ☐Married ☐Divorced ☐Separated	/ /

What is your race?	**What is your Ethnicity?**	**What is your primary language?**	**Do you require translation?**
☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black/African American ☐American Indian/Alaska Native ☐White ☐More than one race ☐Other	☐Hispanic/Latino ☐Not Hispanic/Latino	☐English ☐Spanish ☐Other_____	☐Yes ☐No

Home Phone ☐Best Contact	**Work Phone** ☐Best Contact	**Cell Phone** ☐Best Contact	**Email Address** ☐Best Contact
( )	( ) ext.	( ) ☐Call ☐Text	

Full Address (Street or P.O. Box) (City) (State) (Zip)

Who is your provider at BCHS?	**Employment Status**
	☐Full-Time ☐Part-Time ☐Full-Time Student ☐Part-Time Student ☐Retired ☐Active Duty ☐Unemployed

Please be prepared to present your insurance card, photo identification and proof of income documentation, if necessary.

RESPONSIBLE PARTY (*Complete if different from above*)

Relation to Responsible Party: ☐Self ☐Spouse ☐Child ☐Grandchild ☐Foster Child ☐Guardian ☐Mother ☐Father ☐Other_____

Name of Responsible Party (Last) (First) (Middle) (Jr, Sr, etc.)

Date of Birth	**Gender**	**Social Security Number**	**Marital Status**
/ /	☐Male ☐Female		☐Single ☐Married ☐Divorced ☐Separated

Home Phone ☐Best Contact	**Work Phone** ☐Best Contact	**Cell Phone** ☐Best Contact	**Email Address** ☐Best Contact
( )	( ) ext.	( ) ☐Call ☐Text	

Full Address (Street or P.O. Box) (City) (State) (Zip)

INSURANCE INFORMATION *(If uninsured, please be prepared to present proof of income to qualify for discount program.)*

Primary Insurance (Carrier Name)	**Primary Insurance Address**	**Phone Number**
		( )

Policy Holder ID (Subscriber ID)	**Group #**	**Subscriber Name**	**Relation to Subscriber:**	**Co-Pay** ($)
			☐Self ☐Spouse ☐Child ☐Other_____	

Secondary Insurance (Carrier Name)	**Secondary Insurance Address**	**Phone Number**
		( )

Policy Holder ID (Subscriber ID)	**Group #**	**Subscriber Name**	**Relation to Subscriber:**
			☐Self ☐Spouse ☐Child ☐Other_____

If you have more than two insurances, please provide the additional information at the time of registration.

ADDITIONAL REQUIRED INFORMATION

How many any individuals reside in your household?	**How often are you paid?**	**What is your gross income (before taxes) during this time period?**
	☐Weekly ☐Bi-weekly ☐Monthly ☐Annually	$

Are you Homeless?	**If Homeless, what is your Living Situation?**	**Are you a Veteran?**
☐Yes ☐No	☐Shelter ☐Transitional ☐Staying with Family or Friends (Doubling Up) ☐Street ☐Other_____	☐Yes ☐No

Are you an Agricultural Worker?	**How did you hear about BCHS?**
☐Yes ☐No If Yes, which are you: ☐Migrant ☐Seasonal	☐Friend/Family ☐Health Fair ☐Other_____

Emergency Contact (Name, Address, Phone Number)	**Relation to Patient**

Primary Pharmacy (Name) (Address) (Phone) (Fax)

AUTHORIZATION AND ASSIGNMENT

I do hereby voluntarily consent to medical care at Baptist Community Health Services (BCHS). I hereby authorize all physicians and their assistants including Physician Assistants and Nurse Practitioners employed by BCHS to use such diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that Physician Assistants and Nurse Practitioners are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I also assign the claim payments to be made payable to BCHS. I agree to the release of information to Medicare, Medicaid and third party payors. I understand that some of the services that may be ordered may not be covered under Medicare, Medicaid and other insurance and that I am responsible for any amount that is not paid. THIS AUTHORIZATION AND ASSIGNMENT IS A PERMANENT ONE-TIME SIGNATURE WHICH WILL REMAIN ON FILE AND WILL BE USED FOR FUTURE CLAIMS. I MAY REVOKE IT AT ANY TIME BY WRITTEN NOTICE.

Signature of Patient/Responsible Party: _____ **Date:** _____