PrairieStar Health Center Patient Registration Form

1600 N Lorraine Ste 110 Hutchinson, Kansas 67501

Last name:____ First name _____________________________

SS# _________________________ Date of Birth ________________________ Gender M F

Patient Address: ____________________________________ apt # _________ PO Box _____________

City ____________________________________ State _____ Zip code ___________ County ___________

Patient phone: __________________________ Alternate phone __________________________________

E-mail address____

Employer name: __________________________________ phone # _______________________________

Emergency contact: _______________________________ phone# _______________________________

Relationship to you: _____________________ Language spoken in the home ________________________

Names of person whom you may share my medical, dental or account information with:

_____________________________________ Phone # _______________ relationship: _______________

Do you need assistance with an interpreter: Yes No?

How did you hear about us? _____________________ Preferred Pharmacy: _________________________

Marital Status: ___Single ___Married ___Divorced ___Windowed

Student Status: ___Full time ___Part time ___ not in school

Employment Status: ___ Full time ___ part time ___ retired ___ not employed

Race: (mark all that apply) Amer. Indian/Alaska Native Asian White

Black/ African American Native Hawaiian Pacific Islander

Ethnicity: Are you Hispanic or Latino? Yes No

Are you a veteran? Yes No

Housing Status: **Not homeless** if homeless circle your current situation:

Street Shelter Transitional housing doubling up (temporarily staying with friend/relative)

Agricultural Status: Not agricultural worker Seasonal worker

Dependent of seasonal worker Migrant worker Dependent of migrant worker

TURN OVER

Person Responsible for the Bill:

Name: ____ Relationship to patient: ___________________

Date of Birth ______________________ SS# ______________________ Gender M F

Address: ____

Home phone ____________________________________ Cell phone ___________________________

Employer: _____________________________________ Employer phone: ________________________

Insurance Information:

Do you have medical Insurance? Yes No If Yes, please provide copy of insurance card

Name of Insurance company(s) ____

Name and card holder: ___________________________________ Date of birth __________________

Relationship of patient to card holder ____

Do you have dental insurance?

Yes No If Yes, please provide copy of insurance card

Name of Insurance company(s) ____

Name and card holder: ___________________________________ Date of birth __________________

Relationship of patient to card holder ____

Payment Agreement: I hereby certify that the above information is true. I agree to promptly and fully pay any charges for services I received at PrairieStar Health Center. I understand I will be responsible for charges not paid by my insurance.
Assignment of Benefits: I hereby assign and authorize direct payment to PrairieStar Health Center of all insurance payments or other third party payers.
Consent for Treatment: I hereby request and give consent for the health care professional at PrairieStar Health Center to provide medical and dental treatment to me and/or my family.
HIPAA Consent: I hereby consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I understand I may have a copy of PrairieStar Health Center's notice of privacy practice, which explains how my information will be used and my health information rights.

Patient Signature ___________________________________ Date_________________________