Patient Registration

PRAIRIE STAR Health Center

PATIENT INFORMATION

LAST NAME	FIRST		MIDDLE
SOC SEC #	DATE OF BIRTH		GENDER AT BIRTH ☐ M ☐ F
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE		WORK PHONE
EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)			
PREFERRED PHARMACY			

PLEASE CHECK ALL THAT APPLY

RACE	HOUSING	GENDER IDENTITY
☐ AFRICAN AMERICAN	☐ HOMELESS/TRANSITIONAL	☐ MALE
☐ ALASKAN NATIVE	☐ MEADOWLARK COMMONS	☐ FEMALE
☐ AMERICAN INDIAN	☐ FOX RUN	☐ TRANSGENDER:
☐ ASIAN	☐ NOEL	☐ MALE / FEMALE-TO-MALE
☐ NATIVE HAWAIIAN	☐ CRISIS CENTER	☐ FEMALE / MALE-TO-FEMALE
☐ PACIFIC ISLANDER	☐ STREET	☐ OTHER
☐ WHITE	☐ LIVING WITH FRIEND	☐ CHOOSE NOT TO DISCLOSE
ETHNICITY	**EMPLOYMENT**	**SEXUAL ORIENTATION**
ARE YOU HISPANIC/LATINO?	☐ FARM WORKER	☐ LESBIAN, GAY OR HOMOSEXUAL
☐ YES ☐ NO	☐ MIGRANT WORKER	☐ STRAIGHT OR HETEROSEXUAL
ARE YOU A VETERAN?	☐ SEASONAL WORKER	☐ BISEXUAL
☐ YES ☐ NO		☐ SOMETHING ELSE
PREFERRED LANGUAGE		☐ DON'T KNOW
☐ ENGLISH		☐ CHOOSE NOT TO DISCLOSE
☐ SPANISH	**COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE**	
☐ OTHER:	**MOTHER'S NAME**	
☐ INTERPRETER NEEDED	**FATHER'S NAME**	

INSURANCE INFORMATION (We will need a copy of your insurance card(s))

HEALTH INSURANCE COMPANY			
NAME OF POLICY HOLDER			DATE OF BIRTH
POLICY HOLDER'S RELATIONSHIP TO PATIENT?	☐ SELF	☐ SPOUSE	☐ PARENT ☐ OTHER
DENTAL INSURANCE COMPANY			
NAME OF POLICY HOLDER			DATE OF BIRTH
POLICY HOLDER'S RELATIONSHIP TO PATIENT?	☐ SELF	☐ SPOUSE	☐ PARENT ☐ OTHER

PERSON RESPONSIBLE TO PAY THE BILL

LAST NAME	FIRST		MIDDLE
SOC SEC #	DATE OF BIRTH		GENDER ☐ M ☐ F
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE		WORK PHONE
EMAIL ADDRESS	EMPLOYER		

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EMERGENCY CONTACT	
EMERGENCY CONTACT NAME	PHONE #
RELATIONSHIP TO PATIENT? ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	

PAYMENT AGREEMENT
I hereby certify that the above information is true. I agree to promptly and fully pay any charges and services I receive at PrairieStar Health Center. I understand I will be responsible for charges not paid by my insurance. I understand I am responsible to check with my insurance provider to see which services are covered. I understand that delinquent accounts are subject to collection activity, including referral to collection agency.
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.
ADDITIONAL CHARGES
I understand if PrairieStar obtains a biopsy, HPV test or pap smear, I will receive a bill from the facility interpreting the test, and that I am responsible for these charges.

SIGNATURE OF PATIENT OR GUARDIAN	DATE
SIGNATURE OF PERSON RESPONSIBLE FOR BILL	DATE