# 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 | ☐ LOW INCOME/PUBLIC HOUSING | ☐ MALE |
| ☐ ALASKAN NATIVE | ☐ HOMELESS/TRANSITIONAL | ☐ FEMALE |
| ☐ AMERICAN INDIAN | ☐ MEADOWLARK COMMONS | ☐ TRANSGENDER: |
| ☐ ASIAN | ☐ FOX RUN | ☐ MALE / FEMALE-TO-MALE |
| ☐ NATIVE HAWAIIAN | ☐ NOEL | ☐ FEMALE / MALE-TO-FEMALE |
| ☐ PACIFIC ISLANDER | ☐ CRISIS CENTER | ☐ OTHER |
| ☐ WHITE | ☐ STREET | ☐ CHOOSE NOT TO DISCLOSE |
| **ETHNICITY** | ☐ LIVING WITH FRIEND | **SEXUAL ORIENTATION** |
| ☐ ARE YOU HISPANIC/LATINO? | **EMPLOYMENT** | ☐ LESBIAN, GAY OR HOMOSEXUAL |
| ☐ YES ☐ NO | ☐ FARM WORKER | ☐ STRAIGHT OR HETEROSEXUAL |
| ☐ ARE YOU A VETERAN? | ☐ MIGRANT WORKER | ☐ BISEXUAL |
| ☐ YES ☐ NO | ☐ SEASONAL WORKER | ☐ 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 | | EMPLOYER PHONE |

# Patient Registration

PRAIRIESTAR Health Center

| EMERGENCY CONTACT & PERMISSION TO SHARE PROTECTED HEALTH INFORMATION | |
|---|---|
| EMERGENCY CONTACT NAME | PHONE # |
| RELATIONSHIP TO PATIENT? ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER | |
| **MAY WE SHARE PHI WITH THIS PERSON?** ☐ **YES** ☐ **NO** | |

**SELECT THE INCOME THAT BEST DESCRIBES YOUR SITUATION (This helps us with our grant funding)**

**1. SELECT THE NUMBER OF PEOPLE IN THE HOUSEHOLD.**

**2. UNDER THE NUMBER SELECTED, SELECT THE APPROXIMATE COMBINED HOUSEHOLD INCOME.**

| | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 |
|---|---|---|---|---|---|---|---|---|
| HOUSEHOLD INCOME UNDER | ☐ $12,060 | ☐ $16,240 | ☐ $20,420 | ☐ $24,600 | ☐ $28,780 | ☐ $32,960 | ☐ $37,140 | ☐ $41,320 |
| HOUSEHOLD INCOME BETWEEN | ☐ $12,061 to $18,089 | ☐ $16,240 to $24,359 | ☐ $20,421 to $30,629 | ☐ $24,601 to $36,899 | ☐ $28,781 to $43,169 | ☐ $32,961 to $49,439 | ☐ $37,141 to $55,709 | ☐ $41,321 to $61,979 |
| HOUSEHOLD INCOME BETWEEN | ☐ $18,090 to $24,119 | ☐ $24,360 to $32,479 | ☐ $30,630 to $40,839 | ☐ $36,900 to $49,199 | ☐ $43,170 to $57,559 | ☐ $49,440 to $65,919 | ☐ $55,710 to $74,279 | ☐ $61,980 to $82,639 |
| HOUSEHOLD INCOME OVER | ☐ $24,120 | ☐ $32,480 | ☐ $40,840 | ☐ $49,200 | ☐ $57,560 | ☐ $65,920 | ☐ $74,280 | ☐ $82,640 |

**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 |