BAY AREA COMMUNITY HEALTH – Patient Registration Form

Revised 05/2020

Patient Name: _____
Last First Middle

Address: _____
Street Apt. # City Zip

Phone #: (____)_____ (____)_____ (____)_____
Home Work Cellular

Do you have a **Social Security Number?** ☐ Yes ☐ No Social Security Number: _____

Is your Social Security # for employment only? ☐ Yes ☐ No If Student, School Name: _____

Date of Birth: _____ Sex at birth: ☐ Male ☐ Female
Month / Day / Year

Please indicate if it is OK for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions.
This should be a phone number where **only you**, **or anyone that you are comfortable** with hearing your medical information.

Phone Number that is OK to leave message on (____) _____ ☐ YES you may leave a message with health information ☐ Do not leave message with health information

How may we contact you? Please select all that apply: ☐ Mail ☐ Text ☐ Phone ☐ Email: _____

Living situation: where did you spend last night? ☐ My regular home/ apartment ☐ Shelter ☐ Doubled up ☐ Street/ Vehicle ☐ Transitional/ permanent supportive housing ☐ Other

How did you hear about us: ☐ Radio ☐ Flyer ☐ Event ☐ Friend/Relative ☐ Internet ☐ Other: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other ☐ Choose not to disclose

Sexual Orientation ☐ Lesbian/Gay ☐ Bisexual ☐ Don't know ☐ Straight (not lesbian or gay) ☐ Something else ☐ Chose not to disclose

Ethnicity: ☐ Non-Latino/Hispanic ☐ Latino/Hispanic

Race: ☐ White ☐ African American/Black ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander

Education level completed: ☐ Less than high school graduate ☐ High school graduate ☐ Some College/Associate's Degree ☐ Bachelor's degree or higher

Are you a veteran? ☐ Yes ☐ No

Are you a migrant worker? ☐ Yes ☐ No

Income: How much money does your household make total before taxes? Include any money that any person living in your house brings in:

$_____ circle one: every week every 2 weeks every month every year

Household Size: Number of persons living with you in your house? _____

What language should your information be provided in? ☐ English ☐ Spanish ☐ Mandarin ☐ Hindi ☐ Farsi ☐ Vietnamese ☐ Other _____

Can you speak with your provider in English? ☐ Yes ☐ No

In Case of Emergency
Friend or Relative to Contact: _____ _____ (____)_____
Name Relationship Telephone #

If minor, mother/guardian's name: If minor, father/guardian's name:

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CONSENT FOR TREATMENT

By signing below, I the undersigned patient (or authorized representative, or parent/guardian), consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

Patient Signature or Legal Guardian (if minor):_____ **Date:** _____

Name and relationship (if not patient): _____

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. **I understand that Bay Area Community Health (BACH) provides charges on a sliding fee; based on family size and household annual income, and that services will not be refused due to inability to pay at the time of the visit.**

Responsible Party (Last, first): _____ **DOB:**_____ **Gender:**_____

Relationship to patient:_____ **SS#:** _____

Employment Status: _____ **Primary Phone No.**_____

Address (if different from patient): _____

NOTICE OF PRIVACY PRACTICES

Bay Area Community Health (BACH) Notice of Privacy Practices gives information about how BACH may use and release protected health information (PHI) about you.

I understand that:

- I have the right to receive a copy of BACH's Notice of Privacy Practices
- I may request a copy at any time
- BACH's Notice of Privacy Practices may be revised

By signing below, I acknowledge the above and that I have received a copy of BACH's Notice of Privacy Practices.

Responsible Party: _____ **Date:** _____

Name and relationship (if not patient): _____

ACKNOWLEDGEMENT FOR ADVANCE DIRECTIVES

An Advance Medical Directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

Please select one option below:

☐ Yes, I **do have** an Advance Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

☐ No, I **do not have** an Advance Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

☐ Yes, I **would like** further information on Advance Directives

☐ No, I **would not like** further information on Advance Directives.

If you do have an Advance Directive, please make sure to send a copy to us, in person or by mail (_____)

By signing below, I acknowledge I have received information about Advance Directives

Responsible Party: _____ **Date:** _____

Name and relationship (if not patient): _____