Highland Health Providers

# PATIENT REGISTRATION FORM

**Patient Name:**_____ **Date of Birth:**_____ **SSN:**_____

**Address:**_____ **City/State:**_____ **Zip:**_____

**Home Phone:**_____ **Cell Phone:**_____

**Employer:**_____ **Work Phone:**_____

**Emergency Contact:**_____ **Phone:**_____ **Relationship:**_____

**If under 18 years of age, responsible person for bill:** _____

**Phone:** _____

**Date of Birth of responsible person for bill:** _____

**Would you like to enroll in MyChart patient portal** ___**YES** ___**NO**

**Email:**_____

**Primary Care Physician:**_____

## INSURANCE INFORMATION

☐ **PRIMARY**

**Insurance Name:**_____ **Policy#:**_____ **Effective Date:**_____

**Policy Holder Name:**_____ **SSN:**_____

**Policy Holder DOB:**_____ **Relationship to Patient:**_____

**Employer:**_____ **Work Phone:**_____

☐ **SECONDARY**

**Insurance Name:**_____ **Policy#:**_____ **Effective Date:**_____

**Policy Holder Name:**_____ **SSN:**_____

**Policy Holder DOB:**_____ **Relationship to Patient:**_____

**Employer:**_____ **Work Phone:**_____

☐ **NO ACTIVE INSURANCE**

COMPLETE NEXT PAGE

# Highland Health Providers

Confidential Patient Information for FQHC Sites

## MARK ALL THAT APPLY TO THE PATIENT

**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Partnered ☐ Separated

**Sex at Birth:** ☐ Male ☐ Female

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**Language:** ☐ English ☐ Spanish ☐ Other ☐ ASL/Hearing Impaired

**Situation:** ☐ Veteran ☐ Smoker ☐ Other ☐ Homeless ☐ Visually Impaired ☐ Language Barrier ☐ Migrant Farm Worker

**Race:**

- ☐ American Indian
- ☐ Asian
- ☐ Asian Indian
- ☐ Black / African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Japanese
- ☐ Korean
- ☐ More than 1 race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Unreported
- ☐ Vietnamese
- ☐ White / Caucasian

**Ethnicity:**

- ☐ Non-Hispanic / Latino
- ☐ Hispanic / Latino
- ☐ Unreported

**If Hispanic /Latino, mark one that applies:**

- ☐ Chicano
- ☐ Cuban
- ☐ Mexican
- ☐ Mexican American
- ☐ Mexicano
- ☐ Puerto Rican
- ☐ Spaniard
- ☐ Unreported

**Family Size** (number of people in your home)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ __

**Annual Household Income**

- ☐ less than $14,000
- ☐ $14,000 - $20,000
- ☐ $20,001 - $25,000
- ☐ $25,001 - $30,000
- ☐ $30,001 - $35,000
- ☐ $35,001 - $55,000
- ☐ $55,001 - $85,000
- ☐ $85,001 & over

**For Office Use Only – Sliding Fee Discount**

- ☐ **100% & below**
- ☐ **101% - 150%**
- ☐ **151% - 200%**
- ☐ **200% & over**

END

Highland Health Providers

## PATIENT AUTHORIZATION

For Use/Disclosure of Health Care Information

Patient Name:_____ D.O.B. _____ SSN: _____

Best Contact Phone Number between 9:00 am and 5:00 pm:_____

Please select one of the following choices for your pharmacy:

□ **Highland Health Providers Pharmacy**
**Highland Health Rx**
**1402 N. High St. (Ground level)**
**Hillsboro, Ohio 45133**

**OR**

□ **Pharmacy Name and Location:**
_____
_____
_____

I request and authorize Highland Health Providers, its providers and designee to release private health information about myself by the following names or to the following individuals:

Detailed Message on Answering Machine/Voicemail at "Best Contact Number" above: ⬭ Yes ⬭ No

1) Name: _____ Phone: _____

2) Name: _____ Phone: _____

3) Name: _____ Phone: _____

This authorization expires on: ⬭ Date_____ ⬭ Unlimited

***I understand that information pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy laws.***

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Print Name Relationship to Patient (parent, legal guardian, etc.)

I understand that I may revoke this authorization in writing. If I do, I understand that Highland Health Providers may have previously released information about the individual named above based on the above authorization. I will not hold Highland Health Providers, its providers or designees accountable for releases made prior to receipt of a written revocation or revocation letter.

To revoke this authorization, please write a letter to: Highland Health Providers
1487 North High Street
Suite 102
Hillsboro, Ohio 45133