Hometown Health Center Registration Form

☐ Dexter ☐ Newport ☐ School Based Health Center

☐ **MEDICAL** ☐ **DENTAL** ☐ **BEHAVIORAL HEALTH** ☐ **SPECIALTY** ___________

Patient Full Name: ______________________________ Preferred Name: ______________

Patients Date of Birth: ______________ Age: ______ Patient's Social Security #: ______________

Patient Phone Number: Day ______________ Evening: ______________

Mother or Guardian's Name: ______________ Mother/Guardian Phone Number: ______________

Father or Guardian's Name: ______________ Father/Guardian Phone Number: ______________

Primary Address: ____

City: ______________ State: ______________ Zip: ______________

Email Address: ______________ Religion: ______________

Status (circle one): Married Widowed Single Separated Divorced Life Partner

Student Status (circle one): Full Time Part Time Not a Student GRADE: ______

Smoking Status (circle one): YES NO

Emergency Contact Name: ______________ Relationship: __________ Contact number: __________

Support Person: ______________ Relationship: __________ Contact number: __________

As a Federally Qualified Health Center, we are required to request the following information:

Gender:

__ Male
__ Female

Migrant Worker Status:

__ Migrant
__ No
__ Not a Farm worker
__ Refused to Report
__ Yes
__ Seasonal

Language Barrier:

__ Yes
__ No
__ Primary Language Spoken:

____

Homeless Status:

__ Not homeless
__ Homeless
__ Doubling up
__ Shelter
__ Street
__ Transitional
__ Refuse to Report

Veteran Status:

__ Yes
__ No

Race:

__ Asian Indian
__ Chinese
__ Filipino
__ Japanese
__ Korean
__ Vietnamese
__ Other Asian
__ Native Hawaiian
__ Other Pacific Islander
__ Guamanian or Chamorro
__ Samoan
__ Black/African American
__ American Indian/Alaska Native
__ White
__ More than one race
__ Unreported/Choose not to disclose race

Ethnicity:

__ Mexican
__ Mexican American
__ Chicano/a
__ Puerto Rican
__ Cuban
__ Hispanic/Latino/a
__ Not Hispanic/Latino/a
__ Other
__ Decline to Specify
__ Unknown

Primary Care Provider (PCP): ___________________________ Primary Dentist: ___________________________

Check here if you or your child does not have a PCP _____ Check here if you want HHC to be your PCP _____

Pharmacy Name and Location: ____

Primary Insurance Coverage: ____________________________ ID:_________________Group No:_____________

Subscribers Name:________________________________ Subscribers Date of Birth: ______________________

Relationship to Patient: ____________________________

Additional Insurance Coverage: ____

Residential Information:

I have trouble getting enough food to eat: YES ______ NO ______ My food needs are met: YES _____ NO _____

Smoke Detectors: YES _____ NO _____ Firearms in Home: YES _____ NO _____

Have you ever been a victim of abuse or domestic violence: YES _____ NO _____

Do you feel safe at home? YES _____ NO _____ Do you live alone? YES ______ NO ______

Hobbies/Interests: ____

How did you hear about Hometown Health Center? ____

We ask you for income information because we have programs that may help you!

*****State your household income in one of the following categories listed below******

Number in the household: _______

Household income (list amount): Weekly _______ Biweekly _______ Monthly _______ Yearly _______

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our Billing Department. Although we will compile the necessary forms to file with your insurance company, it is the responsibility of the patient to dispute any services not covered by the insurance company. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

We offer a sliding fee program. There is no cost to apply to the program. The medical visit fee ranges from $10-$45 per visit depending on your household size and income. You may also qualify for reduced charges for dental services.

I acknowledge that I am the legal decision maker as the parent/guardian.

Patient or Guardian Signature____ Date __________

Signature of guardian (if patient is under 18 years)____________________________________ Date __________

HOMETOWN Health Center *is a Federally Qualified Health Center that offers medical services, dental services, behavioral health services,prescription assistance, a sliding fee scale program, and more. Offices in Dexter, Newport and School Based Health Center, Nokomis Regional High-RSU19.*