ACCESS FAMILY CARE
Medical & Dental Clinics

PATIENT REGISTRATION

Please complete the front and back of this form. Please PRINT. Please return completed form(s) to the Front Desk. Thank you.

PATIENT INFORMATION

Date: _____/_____/_____ **Name**: _____
Sex at Birth : ☐ Male ☐ Female FIRST MI LAST

Sexual Orientation: ☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to disclose

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

Primary Language: ☐ English ☐ Spanish ☐ Other _____ ☐ I require an interpreter

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ State Prohibited ☐ Unspecified ☐ White ☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino (Persons of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture) ☐ Not Hispanic or Latino ☐ State Prohibited ☐ Unspecified ☐ Patient Declined

Veteran? ☐ YES ☐ NO

Date of birth: _____/_____/_____**SSN:** _____ **Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Child ☐ Other

Home phone: (_____)_____ **Cell phone**: (_____)_____

Street Address: _____**P O Box:** _____

City: _____**State:** _____**Zip Code:** _____

Email address: _____

Patient Employer: _____ **Phone**: (_____)_____

Does the patient reside in a nursing home or residential care facility? ☐ YES ☐ NO If **YES**, what is the name of the facility where the patient resides? _____Phone number: (_____)_____

SPOUSE INFORMATION (if applicable)

Name: _____**Date of birth:** _____/_____/____**SSN**:_____
FIRST MI LAST
Employer: _____ **Phone**: (_____)_____

EMERGENCY CONTACT INFORMATION

Name and telephone number of someone who does not live in your household

Name: _____ **Relationship to Patient**: _____
FIRST LAST
Phone: (_____)_____

RESPONSIBLE PARTY INFORMATION

Complete this section if the Responsible Party is NOT the Patient

Relationship of Responsible Party to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other _____

NAME: _____ **Sex:** ☐ Male ☐ Female
FIRST MI LAST

Date of birth: _____/_____/_____ **SSN**: _____

IF ADDRESS IS NOT THE SAME AS THE PATIENT: Street: _____ **P O BOX** _____

City: _____**State:** _____ **Zip Code**: _____**Home phone**(_____)_____

Employer: _____ **Phone**: (_____)_____

INSURANCE INFORMATION

Please present All insurance cards to the Front Desk each time you check-in

Mark Insurance Type below:

Medical Insurance: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Individual policy ☐ Other _____

Dental Insurance: ☐ Medicaid ☐ Commercial ☐ Individual Policy ☐ Other _____

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Number of Persons in Household: Adults _____ Children (<18 years old) _____

Estimated Annual Household Income: ☐ $10,000 or below ☐ $10,001 - $20,000 ☐ $20,001 - $30,000 ☐ $30,001 - $40,000 ☐ $40,001 - $50,000 ☐ $50,001 and over

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CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

- I give my consent as the patient or primary legal custodian or joint legal custodian of the patient for any treatment or procedure deemed necessary by the professional staff of ACCESS Family Care.
- I understand this treatment may include x-rays and/or lab work. I understand that an emergency dental visit may consist of a diagnosis of the condition and treatment necessary to relieve discomfort. However final treatment may require additional visits.
- I give permission for ACCESS Family Care to furnish any information needed for my or the patient's billing and treatment.
- I agree to be financially responsible for all charges and understand payment in full is expected at the time of service.
- I request that payment of Medicare, Medicaid or other insurance company benefits made on my behalf or that of the patient's to be assigned to ACCESS Family Care.

_____I have received a copy of the ACCESS Family Care Notice of Privacy Practices. I understand that it is my responsibility to read
INITIALS this notice and ask any questions I might have.

_____ I have received a copy of the ACCESS Family Care Patient Rights. I understand it is my responsibility to read and follow the
INITIALS information contained in this notice.

_____ I have received a copy of the ACCESS No-Show Patient Agreement. I understand that attendance issues may cause me to be
INITIALS dismissed as a patient with ACCESS Family Care and I agree it is my responsibility to follow this policy.

- I agree that my consent is valid as long as I am a patient at ACCESS Family Care.

_____ _____
Signature of Patient/Responsible Party **Date**

_____
Signature of ACCESS Family Care Staff Member