Ilanka Community Health Center
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Previous Last Name: _____ Preferred Name: _____

SSN: _____ Date of Birth: _____ Gender: □ Male □ Female

If minor patient, Name of Guarantor / Responsible Party: _____

MAILING ADDRESS _____

PHYSICAL ADDRESS _____

City: _____

State: _____ Zip: _____

Preferred Contact Phone #: _____

Email Address: _____

PERMANENT ADDRESS _____

City: _____

State: _____ Zip: _____

Permanent Home Phone #: _____

Mobile Phone #: _____

Please select a Primary Care Provider:

Dr. Benjamin Head: ◯ Dr. Brian Iutzi: ◯

Delia Reyes, FNP: ◯

Bios available, please request at Front Desk

PATIENT EMPLOYER: □ Minor patient □ Unemployed □ Disabled □ Retired Retirement Date: _____

Name of Employer (If employed): _____

Employer Phone #: _____ □ Full-time □ Part-time

MARITAL STATUS: □ Divorced □ Life Partner □ Married □ Separated □ Single □ Unknown □ Widowed

DEMOGRAPHIC INFORMATION

Our federal grant requires us to collect and report on this information, in an effort to provide culturally competent healthcare services. The information is reported on the population as a whole, not by specific individual.

Race (select all that apply): □ Alaska Native / American Indian Tribe:_____ □ Asian □ Black / African American □ Native Hawaiian □ Other Pacific Islander □ White □ Choose Not to Disclose Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Choose not to disclose	Total number in your household: _____ Annual Household income: _____ Would you like to apply for sliding fee discounts? □ Yes □ No **Our federal grant requires us to collect and report on household income information for all patients regularly (not only patients applying for a sliding fee discount).* Are you homeless? □ Yes □ No Are you a migrant or seasonal worker? □ Yes □ No	Preferred Language: □ English □ Other (please identify) _____ Interpreter Required? □ Yes □ No Veteran Status: *(Have you ever served in the U.S. Military?)* □ Yes □ No

PRIVACY PRACTICES ACKNOWLEDGEMENT:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review the Notice.

Printed Name: _____ (□ minor) Signature: _____

Date: _____ Relationship to minor patient: _____

BILLING INFORMATION

Guarantor / Responsible Party □ patient / same as above

Last Name: _____ First Name: _____ Middle: _____

SSN: _____ Date of Birth: _____ Gender: □ Male □ Female

MAILING ADDRESS _____ Home Phone: _____

PHYSICAL ADDRESS _____ Other Phone: _____

City: _____ State: _____ Zip: _____

EMPLOYER: (□ no employer) _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____Policy # _____Group #: _____

Policy Holder Name: _____Date of Birth: _____SSN: _____ Gender: _____

Relationship to Patient: _____Employer: _____ Work Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Policy # _____ Group #: _____

Policy Holder Name: _____

Date of Birth: _____SSN: _____ Gender: _____

Relationship to Patient: _____

Employer: _____ Work Phone: _____

TERTIARY INUSURANCE INFORMATION:

Insurance Company: _____

Policy # _____ Group #: _____

Policy Holder Name: _____

Date of Birth: _____ SSN: _____ Gender: _____

Relationship to Patient: _____

Employer: _____ Work Phone: _____

EMERGENCY CONTACT:

Name: _____

Date of Birth: _____

Phone: _____

Relationship to Patient: _____

NEXT OF KIN:

Name: _____

Date of Birth: _____

Phone: _____

Relationship to Patient: _____

CONSENT FOR EVALUATION AND TREATMENT:

Ilanka Community Health Center provides comprehensive Primary Care and Behavioral Health services. Since wellness involves body and mind, our providers may involve other healthcare specialists such as Behavioral Health Clinicians, a Care Coordinator or telehealth providers as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure continuity of care. *If you prefer to limit the sharing of information, please inform the Front Desk Staff before your appointment.*

By signing this form, I agree that I have read or had this form read and/or explained to me, that I understand it and that my questions have been answered. I agree to provide accurate information.

Thus, I hereby consent for Ilanka Community Health Center to evaluate and administer treatment for myself and/or child(ren) as set forth above, including any procedures that ICHC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally authorized to make such decisions.

Patient Name:_____ Patient DOB: :_____

Signature:_____ Date:_____

Printed Name if Parent/Guardian Signing:_____