COMMUNITY HEALTH CENTERS OF SOUTH CENTRAL TEXAS, INC.
REGISTRATION FORM

(PLEASE PRINT AND FILL OUT COMPLETELY)

Today's Date:	Account No.	PCP:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Other_____ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Employer:_____ Language:_____	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	County:	State:	ZIP Code:

Homeless Status: ☐Shelter ☐ Transitional ☐ Doubling up ☐ Street ☐ Not Homeless ☐ Unknown ☐ Other	Worker Status : ☐ Seasonal ☐ Migrant ☐ NA Public Housing Assistance : ☐ Yes ☐ No Veteran Status: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No	Texas Resident: (Yes) (No)	Need Interpreter: (Yes) (No)

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. ☐ Family ☐Radio ☐ Friend ☐ Facebook ☐ Newspaper

☐ Website(www.CHCSCT.com) ☐Outreach ☐ Health Fair ☐ Other _____

Race: ☐Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Black/African American ☐ Caucasian ☐ American Indian/Alaskan Native ☐ Native American ☐ Asian Pacific American ☐ Subcontinent Asian American ☐ More than one race ☐ Other Race

Ethnicity: ☐Hispanic/Latino ☐ Not Hispanic ☐ Unreported/ Refused to Report

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )
Is this person a patient here?	☐ Yes ☐ No		

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Superior ☐ Not Insured

☐ Other	☐ Welfare *(Please provide coupon)*	Effective Date:	Expiration Date:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: (Must be different from above numbers) ( )	Work phone no.: ( )

FAMILY INFORMATION

Please list all members living in the household including yourself

Name	Date of Birth	Relationship to Patient	Highest level of education	Preferred Language Spoken

Financial Information and Fees: You may be eligible for a discount on your clinic fees. If you would like to be considered for a possible discount, we will need to collect household income information. You will need to provide proof of income such as W2 Forms or check stubs. All of this information is *confidential*.

Please List Child Care Expenses:_____

Name of Family Member	Gross Income
	$
	$
	$

Total Gross Annual Income for Household	**$**

FOR OFFICE USE ONLY: ID verification by staff: Yes_____No:_____
Residency Verification by Staff: Yes_____No_____

Income Verification: _____W2/Income tax return _____Check Stubs _____Letter of Support ____Other

Financial Class:_____ %Pay: __0% ___25% ___50% ___75% ___100%

I wish to be contacted in the following manner. I understand that this authorization is in effect until I revoke it in writing (check all that apply)

Telephone Communication:	☐ Leave a Detail Message	☐ Leave Message with Call back Number	☐ Leave Message on Voicemail/Answering Service
Written Communication:	☐ Mail to home address	☐ Mail to work/office address	☐ Send Via Fax No._____ ☐ Send Via E-Mail Address:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Community Health Centers of South Central Texas, Inc**. or **insurance company** to release any information required to process my claims.

Patient/Parent/Guardian signature	*Date*
Staff Signature	*Date*