REGISTRATION FORM

Section I. CLIENT INFORMATION: (To be completed by **ALL clients**)

Please, **PRINT** clearly the following information for the client/patient who has an appointment today:

Last Name: _____ First Name: _____ Middle Initial: _____

** If you were seen in our clinic within the last 60 days **AND** your personal information has not changed, check here ☐ and **PROCEED** to the next section. Otherwise, please complete the information requested in this box:

Address: _____ Gender: Male ☐ Female ☐

City, State, Zip _____ Veteran: Yes ☐ No ☐

DOB: _____ Race: _____ Hispanic: Yes ☐ No ☐

Languages Spoken: _____ I Need Translation Services: Yes ☐ No ☐

Phone Number: _____ Type: Home ☐ Cell ☐

Section II. INSURANCE INFORMATION (To be completed only **BY NEW CLIENTS WITH INSURANCE OR CURRENT CLIENTS IF INSURANCE COVERAGE HAS CHANGED**

If insured, please complete the following information for the client/patient who has an appointment today:

What is your Primary Insurance? _____

Who is listed as the Insured/Member on the Insurance Card? _____

MEMBER NUMBER: _____ GROUP NUMBER: _____

What is your relationship to the Insured/Member? _____

Did you bring your Insurance Card? YES NO

Do you have a Secondary Insurance? YES NO

If YES, What is your Secondary Insurance? _____

Who is listed as the Insured/Member on the Insurance Card? _____

MEMBER NUMBER: _____ GROUP NUMBER: _____

What is your relationship to the Insured/Member? _____

Did you bring your Insurance Card? YES NO

Section III. FAMILY AND INCOME INFORMATION: (To be completed by **ALL INSURED CLIENTS every 6 months** - Include anyone living in the same household and related)

If under the age of 21, unmarried and living with parents, complete the following information for parents as well:

FAMILY MEMBER'S NAME, DATE OF BIRTH, AND SOCIAL SECURITY NUMBER	EMPLOYER / SOURCES OF INCOME (Include child support received, unemployment, Worker's Comp, etc.)	ESTIMATED ANNUAL GROSS INCOME
Family Size =	Total Annual Gross Income =	
TOTAL ANNUAL INCOME DEDUCTIONS: (Child Care, Child Support paid, etc.)		

FOR OFFICE USE ONLY - ACKNOWLEDGMENTS, INITIALS AND SIGNATURE

☐ I understand that starting on July 1st, 2013, I will be responsible to pay in full for any co pays, deductibles and share of costs (SOC) that my insurance determines are my responsibility, as well as any bills that my insurance refuses to pay.

☐ I understand that if I do not have insurance, I may be asked to make an appointment with a Financial Counselor to help me find ways to cover for the cost of my health care. If I decline this option or select not to bill my insurance, I will be responsible for 100% of the cost of the services I receive.

☐ I agree to notify this Health Care Center immediately if I lose my insurance coverage and/or my financial situation changes. If that were to happen, I will make an appointment with a Financial Counselor to update my records.

_____ _____ _____

SIGNATURE PRINTED NAME DATE