Suncoast Community Health Centers, Inc.

For office use only Site: _____ Account #: _____

PATIENT REGISTRATION

Patient Legal Name	Preferred Name/Pronouns

Please be aware that your name and sex should be reported on this document, in the same way that it is listed with your insurance. This is so that your insurance may be properly billed. If your preferred name or pronouns are different from this, please let us know.

Sex at birth □ M □ F (please check one) Marital Status □ S □ M □ D □ W □ Other:

Date of Birth Month / Day / Year Social Security #

Home Phone	Cell Phone			
Mailing Address	Apt. #	City	State	Zip Code
Street Address	Apt. #	City	State	Zip Code

Can confidential messages (appointment reminders, etc.) be left on your answering machine or voicemail? □ Yes □ No

Preferred method of contact □ Home (Voice) □ Cell (Voice) □ Cell (Text Messages)

E-mail Would you like access to Patient Portal? □ Yes □ No

Language Preference □ English □ Spanish Are you a student? □ Yes □ No

Race
□White □Black/African American □Asian □American Indian/Alaska Native □Native Hawaiian □Other Pacific Islander □Other (Specify):

Ethnicity: □ Hispanic/Latino □ Non-Hispanic

Seasonal Farm Worker □ Yes □ No	Migrant Farm Worker □ Yes □ No
United States Military Veteran □ Yes □ No	Homeless □ Yes □ No
Do you have insurance? □ Yes □ No Insurance Name Policy #	Are you employed? □ Yes □ No Employer Name

In Case of Emergency Contact:

Name	Relationship	HIPAA Access □ Yes □ No		
Phone #	Street Address	City	State	Zip Code

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	S.S. #	EMPLOYED Yes or No
1. Head of Household				
2. Remaining household members				
3.				
4.				
5.				
6.				

For office use only					
Total # of Members Applying for Sliding Fee Discount:			Total Income Verified:		
Circle Sources of Income Used: Paystubs Unemployment SSI/SSDI Retirement/Pension Tax Return Alimony Child Support Cash Assistance Other: _____				Frequency: Weekly, Bi-weekly, Monthly, Annually	
Qualified Poverty Level	Qualified Medical Slide	Qualified Dental Slide	Qualified Family Planning Slide (Title X)	Slide Effective Date	Slide Termination Date

By signing below, I acknowledge that the above information is true and correct to the best of my knowledge. Additionally, I understand that the Sliding Fee Discount was calculated based on my household size and income and is only valid for 6 months and will be reviewed at every visit. At the expiration of 6 months, I will need to re-apply and provide new proof of income to continue receiving a discount.

_____ _____

Patient/Responsible Party Signature Date Print Name and Signature of SCHC Employee Date

AUTHORIZATION FOR TREATMENT

☐ Initial I authorize the staff of SCHC to provide medical and dental care as needed, and also access Rx history. I authorize payment of medical/dental benefits to SCHC from any third party payer. I understand that I am responsible for payment for services rendered to me by SCHC. I understand services cannot be provided to a minor without the presence of a parent/legal guardian, stepparent, grandparent of the minor, an adult brother or sister of the minor, adult aunt or uncle of the minor or a written/verbal authorization from the parent.

PATIENT RESPONSIBILITY AGREEMENT

☐ Initial I understand that as a patient I have certain responsibilities to my health care provider. I have been provided a copy of the SCHC Patient Responsibility Agreement, and by signing below, agree to do my part. I understand that if I am uninsured and do not provide proof of income I will be classified as a full fee patient and will not be eligible for a discount. I agree to be responsible for services not covered by my insurance based on Suncoast policies. I understand that if I do not comply with these responsibilities, I may be discharged from care as a patient.

_____ _____

Patient/Legal Guardian Date Witness Date

ADVANCED DIRECTIVES

☐ I have been provided information on Advanced Directives.

☐ I have an Advanced Directive and have provided a copy for my medical records.

☐ I do not have an Advanced Directive.

Initial

AUTHORIZATION/CONSENT FOR TREATMENT OF A MINOR

I, _____ hereby authorize _____ to consent to all medical examinations and treatment, and/or dental exam or treatment deemed necessary by SCHC staff for the following minor: _____

(Minor's Name and Date of Birth)

_____ _____

Signature of Parent/Guardian Date Witness Date

HIPAA

☐ Initial I acknowledge that I have been given SCHC's Notice of Privacy Practices.

List of family members or other person, if any, we may inform about your general medical condition, diagnosis, treatment options, and financial responsibility.

1. Name	DOB		Phone #	Relationship
Street Address	Apt. #	City	State	Zip Code
2. Name	DOB		Phone #	Relationship
Street Address	Apt. #	City	State	Zip Code

_____ _____

Patient/Legal Guardian Date Witness Date