



# 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.				
Legal Sex <input type="checkbox"/> M <input type="checkbox"/> F (please check one)		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Preferred method of contact <input type="checkbox"/> Home (Voice) <input type="checkbox"/> Cell (Voice) <input type="checkbox"/> Cell (Text Messages)				
E-mail	Would you like access to Patient Portal? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish		Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other (Specify):				
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic				
Seasonal Farm Worker <input type="checkbox"/> Yes <input type="checkbox"/> No		Migrant Farm Worker <input type="checkbox"/> Yes <input type="checkbox"/> No		
United States Military Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No		Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Insurance Name	Policy #	Employer Name		

In Case of Emergency Contact:				
Name		Relationship		HIPAA Access <input type="checkbox"/> Yes <input type="checkbox"/> 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.				



# Suncoast Community Health Centers, Inc.

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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



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## 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