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|  | Rural Health Corporation of Northeastern Pa |

For office use:

Patient #:

 **Medical / Dental Patient Registration Form
 \*\*\*\*PLEASE NOTE - ALL UNSHADED BOXES ARE REQUIRED\*\*\*\***

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| **Welcome to Rural Health Corporation! To register, please complete this form. Several of the items below help us ensure that we are meeting the needs of the patient population we serve, so please be as thorough as you can. Please let us know if you have any questions or need help in completing this form.**  |
| **Patient Last Name:** | **Patient First Name:** | **MI:** | **Patient Date of Birth:** | **Veteran?** **Yes No** |
| **Patient Address:** | **Patient City:** | **State:** | **Zip code:** | **Preferred Language:** |

**\*\*\*\*PLEASE NOTE! YOU MAY CHOOSE “REFUSED TO REPORT” ON ANY FIELD WITH THAT OPTION BELOW!\*\*\***

|  |  |  |
| --- | --- | --- |
| **Gender:** Please check:[ ]  Female[ ]  Male[ ]  Female to Male/Transgender Male/Trans Man[ ]  Gender queer neither exclusively Male or Female[ ]  Male to Female/Transgender Female/Trans Woman[ ]  Other, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Refused to Report | **Sexual Orientation:** Please check:[ ]  Straight or Heterosexual[ ]  Bisexual[ ]  Lesbian, Gay or Homosexual[ ]  Other, please specify[ ]  Unknown[ ]  Refused to Report | **Race:** Please check:[ ]  Caucasian / White[ ]  African American/Black[ ]  American Indian or Alaska Native[ ]  Asian[ ]  Native Hawaiian / Other Pacific Islander[ ]  Refused to Report |

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| --- | --- | --- | --- |
| **Ethnicity:** Please check:[ ]  White, Not Hispanic / Latino[ ]  Hispanic /Latino[ ]  Another Hispanic, Latino(a) or Spanish Origin[ ]  Cuban[ ]  Mexican, Mexican American, Chicano(a)[ ]  Puerto Rican[ ]  Refused to Report | **Marital Status:** Please check:[ ]  Single[ ]  Married[ ]  Divorced[ ]  Widowed[ ]  Separated[ ]  Life Partner[ ]  Legally Separated[ ]  Unknown | **Number in family:** | **Patient Social Security Number:** |
| **Contact Information/Email:**This will be used for our patient portal, appointment confirmations, and pre-registrations for appointments.Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Contact Information: Cell phone numbers will be used for appointment confirmations and pre-registration requests. Choose one as your preferred number.** |
| **Cell #** [ ]  **PREFERRED#**  | **Home #** [ ]  **PREFERRED#**  | **Work #** [ ]  **PREFERRED#**  |
| **OK to leave a message with detailed info?** **YES NO****Message only with call back number?** **YES NO** | **OK to leave message with detailed info?** **YES NO****Message only with call back number?** **YES NO** | **OK to leave a message with detailed info?** **YES NO****Message only with call back number?** **YES NO** |
| **Personal Representative(s): You may communicate information about me to the following individuals:****Name: Relationship:** |
|  |  |

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| **Emergency Contact Information:** |
| **Name:** | **Relationship to patient:** | **Phone#:** | **Other Phone#:** |

**\*\*\*\*\*PLEASE CONTINUE ON NEXT PAGE\*\*\*\*\***

Med/Dent Form: February 2016; revised 04/2022 1 of 2

Page 2

**Financially Responsible Party (for all uncovered/unpaid balances)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name:** | **First Name:** | **MI:** | **Date of Birth:** |
| **Social Security Number:** |
| **Address:** | **City:** | **State:** | **Zip code:** | **Phone #:** |

 **Primary Insurance Information:** **OR PLEASE CHECK:** [ ] **I DO NOT HAVE INSURANCE AT THIS TIME**

|  |  |
| --- | --- |
| **Insurance Company:**  | **Policy Holder ID #:** |
| **Group #:** | **Relationship of Patient to Policy holder: Please check one:**[ ] **Self** [ ] **Child** [ ] **Spouse** [ ] **Other** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Policy Holder Last Name:** | **Policy Holder First Name:** | **MI:**  | **Policy Holder Date of Birth:** |
| **Policy Holder Address:** | **Policy Holder City:** | **State:** | **Zip code:** | **Policy Holder Social Security#:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Gender:** | **Phone #:** | **Marital Status:**  | **Number in Family:** |

**Secondary Insurance Information OR PLEASE CHECK:** [ ] **I DO NOT HAVE SECONDARY INSURANCE**

|  |  |
| --- | --- |
| **Insurance Company:**  | **Policy Holder ID #:** |
| **Group #:** | **Relationship of Patient to Policy holder: Please check one:**[ ] **Self** [ ] **Child** [ ] **Spouse** [ ] **Other** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Policy Holder Last Name:** | **Policy Holder First Name:** | **MI:**  | **Policy Holder Date of Birth:** |
| **Policy Holder Address:** | **Policy Holder City:** | **State:** | **Zip code:** | **Policy Holder Social Security Number:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Gender:** | **Phone #:** | **Marital Status:**  | **Number in Family:** |

|  |
| --- |
| **For Office Staff Use only: The following have been scanned into the Patient Registration Record:** **(Please check) Insurance Card(s) Patient Identification** **Scanned by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

Med/Dent Form: February 2016; revised 04/2022 2 of 2