PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM

Today's Date: Month / Day / Year

MINOR PATIENT INFORMATION (All of this information is about the minor patient)

Last Name	First Name	MI	Nickname	Social Security #	Birth Date MM / DD / YYYY

☑ Birth Gender:
- ☐ Female
- ☐ Male

☑ Current Gender:
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

☑ Gender Identity:
- ☐ Choose not to Disclose
- ☐ Female
- ☐ Female-to-Male (FTM) Transgender Male
- ☐ Genderqueer, neither exclusively Male or Female
- ☐ Male
- ☐ Male-to-Female, (MTF) Transgender Female
- ☐ Other, please specify ____

☑ Sexual Orientation:
- ☐ Bisexual
- ☐ Choose not to disclose
- ☐ Don't Know
- ☐ Lesbian, Gay, Homosexual
- ☐ Other:
- ☐ Straight or heterosexual

☑ Preferred Pronoun:
- ☐ Asked but unknown
- ☐ Declined to Answer
- ☐ He, Him, His
- ☐ Other
- ☐ She, Her, Hers
- ☐ They, Them, Theirs
- ☐ Ze, Hir

Patient Residence	City	State	Zip

☑ Preferred Language:
☐ English ☐ Spanish
☐ French ☐ German
☐ Nepali ☐ Russian
☐ Other: ____________

☑ Religion (of patient):
☐ Christian ☐ Agnostic ☐ Atheist
☐ Buddhist ☐ Hindu ☐ Unknown
☐ Islamic ☐ Scientology
☐ Other: ______________

☑ Marital Status (of patient):
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Life Partner
☐ Other: _________________

☑ Student Status:
- ☐ Full Time Student
- ☐ Not a Student
- ☐ Part-Time Student

☑ All that apply:
- ☐ Veteran
- ☐ Smoker
- ☐ None of the Above

Can we send notifications?
☑ All that Apply:

☐ Opt Out

☐ Email ☐ Phone ☐ Text ☐ Voicemail

☑ Which Contact You Prefer:

☐ Phone Number	☐ Cell Phone ☐ Landline
Relationship to Pt	

Emergency Contact Name	☐ Email Address
Emergency Contact Relationship	Relationship to Pt

STATISTICS REQUIRED FOR GOVERNMENT REPORTING

☑ Ethnicity (of patient):
- ☐ Hispanic or Latino
- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Not Hispanic or Latino
- ☐ Decline to specify

☑ Race (of patient):
(Check all that apply)
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Decline to Specify

☑ All that Apply (for the patient):
- ☐ Homeless
- ☐ Migrant Farm Worker
- ☐ Language Barrier
- ☐ None of the Above

☑ Tax Filing Status

☑ Minor (default for patients under 18)

INSURANCE INFORMATION (Please provide insurance card to office)

Primary Insurance	Policy #	Group #	Effective Date	Co-Pay $
Policy Holder Name		Relationship to Patient		
Secondary Insurance	Policy #	Group #	Effective Date	Co-Pay $
Policy Holder Name		Relationship to Patient		
Tertiary Insurance	Policy #	Group #	Effective Date	Co-Pay $
Policy Holder Name		Relationship to Patient		

PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM

Today's Date: Month / Day / Year

PARENT/RESPONSIBLE PARTY INFORMATION (Parent/Guardian Information)

Last Name	First Name	MI	Nickname	Social Security #	Birth Date MM / DD / YYYY
Billing Address (If different from residence address)		City		State	Zip
Phone Number		Email Address			

HOUSEHOLD INCOME

It is the policy of Primary Health Solutions to provide essential services to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). Discounts will be based on income and family/household size, only. Please complete the following information to determine if you or members of your family are eligible for a discount.

**For the purpose of assistance, family/household is defined as: anyone who lives in the same house/address.*

Section (a): Total combined Income for all persons working in the household.

Section (b): How often you get paid.

Section (c): Any additional income received in the household.

Section (d): Total number of people the household income supports.

ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

(a) Total Household Income before Taxes:	(b) ☑ Frequency:	(c) Other Income:	(d) Total Number of People Supported by Income:
$	☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	$	

DOCUMENTATION OF NO INCOME

If you have reported $0 household income in the section above, please explain how you are meeting your daily needs.

ACKNOWLEDGEMENT AND CONSENT

I understand that to determine eligibility for the sliding fee program, I must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). If Self-employed, I must submit detail of the most recent three months of income and expenses for the business. Primary Health Solutions may request additional information before the patient named above is approved for a discount.

I agree to inform Primary Health Solutions of any changes in circumstance that may affect the patient's eligibility. Any intentional false or fraudulent information provided will be grounds for denial of services for the patient. I understand the information above must be updated every twelve (12) months, or if there are any changes in family size or household income.

I have received information explaining the Sliding Fee Scale Program and I agree to follow its terms. I understand that any discount I am eligible for, will apply to all services received at any of the Primary Health Solutions practices, but not those services or equipment that are purchased from outside, including reference laboratory testing, medications, and x-ray interpretation by a consulting radiologist, and other such services. If I elect to pay the full fee or do not qualify for a discount, I may receive a bill if all services provided are not covered by the fee paid upfront.

I certify that all information given by me is true. I consent to any services rendered to me or my dependents by the provider. I understand this authorization will also permit the center to release information related to my medical records to other offices to assist in my continuing care. I acknowledge full financial responsibility for services rendered by Primary Health Solutions. I authorize the release of information to my insurance carrier and authorize payment directly to Primary Health Solutions. I have read and fully understand the above.

Patient Name/Responsible Party (Print)	*Signature of Patient/Responsible Party*	*Date*