PARKTREE COMMUNITY HEALTH CENTER – Patient Registration

Revised 04/2023

Patient Name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Street) _____ (Apt. #) _____ (City) _____ (Zip)

Phone #: ( ) _____ (Home) ( ) _____ (Work) ( ) _____ (Cellular)

Do you have a **Social Security Number?** ☐ Yes ☐ No Social Security Number: _____

Is your Social Security # for employment only? ☐ Yes ☐ No Email Address: _____

Date of Birth: _____ (Month / Day / Year) Age: _____ Sex at Birth: ☐ Male ☐ Female

Please indicate if it is OK for us to leave a confidential voice mail that may include test results, prescription information , or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions. This should be a phone number where **only you**, **or anyone that you are comfortable** with hearing your medical information.

Phone Number that is OK to leave message on: ( ) _____ Initials: _____ ☐ Do not leave messages with health information

How many we contact you? Please select all that apply: ☐ Mail ☐ Text ☐ Phone ☐ Email

Living Situation: ☐ Own ☐ Living with friend/relative ☐ Homeless Shelter ☐ Transitional ☐ Rent ☐ Permanent Supportive Housing ☐ Street ☐ Other

Migrant Worker : ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Ethnicity: ☐ Spanish ☐ Mexican American ☐ Mexican ☐ Chicano/a ☐ Latino/ Hispanic ☐ Cuban ☐ Puerto Rican ☐ Non-Latino /Hispanic ☐ Decline to Answer

Race: ☐ White ☐ Japanese ☐ Filipino ☐ Vietnamese ☐ Pacific Islander ☐ Other Pacific Islander ☐ Asian ☐ Korean ☐ Chinese ☐ Other Asian ☐ Native Hawaiian ☐ Alaskan Native ☐ Samoan ☐ Other Asian ☐ Asian Indian ☐ African American ☐ American Indian ☐ Unknown ☐ Guamanian or Chamorro ☐ Choose not to Disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other ☐ Do not wish to disclose

Preferred Pronoun: ☐ Ze, Hir, ☐ He, Him, His, ☐ They, Them, Theirs, ☐ Other ☐ She, Her, Hers, ☐ Declined to answer

Sexual Orientation: ☐ Lesbian/Gay ☐ Bisexual ☐ Do not wish to disclose ☐ Straight ☐ Other

Income: How much money does your household make total before taxes? Include any money that any person living in your house brings in:

$ _____ circle one: every week every 2 weeks every month every year

Household Size: Number of persons living with you in your house? _____

What is your preferred language? _____

Do you request an interpreter for your visit? ☐ Yes ☐ No

Name of Preferred Pharmacy: _____

Pharmacy Phone Number: _____

Health Insurance Type: ☐ Medi-Cal ☐ Medicare ☐ Private ☐ No Health Insurance

Health Plan Name: _____ Subscriber Number: _____

Name of Person Insured/Guarantor: _____

Dental Insurance Type: ☐ Medi-Cal ☐ Medicare ☐ Private ☐ No Dental Insurance

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Revised 02/2020

In Case of Emergency
Friend or Relative to Contact: _____ _____ ( )_____
Name Relationship Telephone #

If minor, mother/guardian's name: _____ If minor, father/guardian's name: _____

CONSENT FOR TREATMENT

By signing below, I the undersigned patient (or authorized representative, or parent/guardian), consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

Patient Signature or Guardian (if minor): _____ **Date** _____

Name and relationship (if not patient) _____

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. **I understand that ParkTree Community Health Center provides charges on a sliding fee; based on family size and household annual income, and that services will not be refused due to inability to pay at the time of the visit.**

Responsible Party: _____ **Date:** _____

Name and relationship (if not patient): _____

NOTICE OF PRIVACY PRACTICES

ParkTree Community Health Center's (PCHC) Notice of Privacy Practices gives information about how PCHC may use and release protected health information (PHI) about you.
I understand that:

I have the right to receive a copy of PCHC's Notice of Privacy Practices
I may request a copy at any time
PCHC's Notice of Privacy Practices may be revised

By signing below, I acknowledge the above and that I have received a copy of PCHC's Notice of Privacy Practices.

Responsible Party: _____ **Date:** _____

Name and relationship (if not patient) : _____

ACKNOWLEDGEMENT FOR ADVANCE DIRECTIVES

An Advance Healthcare Directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.
Please select one option below:

- ☐ I **do have** an Advance Directive / Living Will / Durable Power of Attorney for medical or health care decisions.
- ☐ I **do not have** an Advance Directive / Living Will / Durable Power of Attorney for medical or health care decisions.
- ☐ I **would like** further information on Advance Directives
- ☐ I **would not like** further information on Advance Directives.

If you do have an Advance Directive, please make sure to send a copy to us, in person or by mail (1450 East Holt Avenue Pomona, CA 91767)

By signing below, I acknowledge I have received information about Advance Directives

Responsible Party: _____ **Date** _____

Name and relationship (if not patient) _____