



## PATIENT REGISTRATION

### Patient Information

Name: \_\_\_\_\_  
*First Middle Last*

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender:  M  F

Race:  American Indian/Alaska Native  Asian  Black  White  Native Hawaiian  Other Pacific Islander

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Do you have medical insurance?  Yes  No

If you do not have insurance, would you like to get information about our reduced fee program?  Yes  No

Are you a US veteran?  Yes  No Are you homeless?  Yes  No

### Parent's Information

(Complete this section for a patient less than 18 years old)

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*First Middle Last*

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*First Middle Last*

Is there a Legal Child Custody Agreement?  Yes  No

(If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical/dental treatment for the child or from obtaining information about the child's medical/dental treatment?)  Yes  No

**\*\*\*Please provide proof of parental custody orders or other legal agreements\*\*\***

### Emergency Contact Person

Name: \_\_\_\_\_ / \_\_\_\_\_  
*First Middle Last Relationship to patient*

\_\_\_\_\_ / \_\_\_\_\_  
*Address Phone*

### Person Responsible for Payment

(Complete this section for a patient less than 18 years old)

Name: \_\_\_\_\_ / \_\_\_\_\_  
*First Middle Last Relationship to patient*

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Chart #:

Insurance scanned: yes/no

Date:

Initials:



PERMISSION TO SHARE PROTECTED  
HEALTH INFORMATION

Patient's Full Name: \_\_\_\_\_  
(Last) (First) (Middle)

Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone: \_\_\_\_\_

Keystone Health shares one electronic record. Any person(s) you authorize will have access to your financial/medical/dental and behavioral health information.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone : \_\_\_\_\_ ( you will receive a text message)

E-mail: \_\_\_\_\_ (you will receive an email)

By signing, I give permission to Keystone Health to share my protected health information to the individuals listed. This Permission remains in effect until revoked in writing.

\_\_\_\_\_  
Signature of Patient or Authorized Representative  
*(Patient's 14 years and older must sign if consenting for treatment on own behalf)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Initials

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

**Race-** relates to a persons appearance such as skin color:

- White/Caucasian**   
  **Black/African American**   
  **Asian**   
  **American Indian**  
 **Native Hawaiian**   
  **Other Pacific Islander**   
  **Multi-racial**

**Ethnicity-** relates to nationality and culture:

- Latino/Hispanic**   
  **Non Latino**

**Do you live in public housing:**

- Yes**                     
  **No**

<b>Family Size</b>	<b>Annual Family Income</b>		
1	<input type="checkbox"/> \$12,140 and below	<input type="checkbox"/> \$18,210 and below	<input type="checkbox"/> \$24,280 and below
	<input type="checkbox"/> \$24,281 and above		
2	<input type="checkbox"/> \$16,460 and below	<input type="checkbox"/> \$24,690 and below	<input type="checkbox"/> \$32,920 and below
	<input type="checkbox"/> \$32,921 and above		
3	<input type="checkbox"/> \$20,780 and below	<input type="checkbox"/> \$31,170 and below	<input type="checkbox"/> \$41,560 and below
	<input type="checkbox"/> \$41,561 and above		
4	<input type="checkbox"/> \$25,100 and below	<input type="checkbox"/> \$37,650 and below	<input type="checkbox"/> \$50,200 and below
	<input type="checkbox"/> \$50,201 and above		
5	<input type="checkbox"/> \$29,420 and below	<input type="checkbox"/> \$44,130 and below	<input type="checkbox"/> \$58,840 and below
	<input type="checkbox"/> \$58,841 and above		
6	<input type="checkbox"/> \$33,740 and below	<input type="checkbox"/> \$50,610 and below	<input type="checkbox"/> \$67,480 and below
	<input type="checkbox"/> \$67,481 and above		
7	<input type="checkbox"/> \$38,060 and below	<input type="checkbox"/> \$57,090 and below	<input type="checkbox"/> \$76,120 and below
	<input type="checkbox"/> \$76,121 and above		
8	<input type="checkbox"/> \$42,380 and below	<input type="checkbox"/> \$63,570 and below	<input type="checkbox"/> \$84,760 and below
	<input type="checkbox"/> \$84,761 and above		
9	<input type="checkbox"/> \$46,700 and below	<input type="checkbox"/> \$70,050 and below	<input type="checkbox"/> \$93,400 and below
	<input type="checkbox"/> \$93,401 and above		
10	<input type="checkbox"/> \$51,020 and below	<input type="checkbox"/> \$76,530 and below	<input type="checkbox"/> \$102,040 and below
	<input type="checkbox"/> \$102,041 and above		