



PATIENT REGISTRATION

Patient Information:

Date: _____

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

Address: _____

Social Security Number: _____ Home phone: (____) _____

Date of Birth: _____ Marital Status: _____ Sex: _____

Race: (please circle one) American Indian, Asian, Black, White, Native Hawaiian, Other Pacific Islander

Ethnicity: (please circle one) Hispanic or Latino, Not Hispanic or Latino

Are you a veteran? _____ Yes _____ No. Are you homeless? _____ Yes _____ No

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

Emergency Contact Person:

(Name) (Relationship to patient)

(Phone) (Address)

Person Responsible for Payment:

(Complete only if patient is less than 18 years old)

Name: _____ 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:

Keystone Health
PATIENT'S AGREEMENT TO SHARE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____
(first) (middle) (last)

Please list individuals with whom we may share your medical/dental and/or billing information. This means we can verbally share medical or financial information as well as provide printed copies of items contained in your medical/dental record or billing statements. Any individual listed may also pick up information for you at the office, such as approved prescriptions, lab or test slips, work or school notes, etc. The patient or official designee must initiate and sign a release of information form if a complete copy of the medical/dental record is requested. It is your responsibility to notify Keystone of any changes. This agreement information remains valid until revoked in writing.

Keystone Health utilizes an Electronic Health Record; all Keystone medical sites share one record. Any person you authorize will have access to your information at any Keystone site.

There are specific visits that will require the patient or authorized person/official designee to sign a release. The visits could include behavioral health, HIV and confidential women's visits.

If the patient is under age 18, the parent and/or guardian should be listed below.

Financial/Medical/Dental Information

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 care.

Cell phone: _____ (You will receive a text message)

E-mail: _____ (You will receive an email)

By signing, I give my permission to Keystone Health to share my Protected Health Information, as permitted by law or regulation; to the individuals listed and that I received a copy of Keystone Health Center's Financial Agreement and Notice of Privacy Practices.

Print Name _____ Relationship _____

Signature _____ 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

Family Size	Annual Family Income		
1	<input type="checkbox"/> \$15,075 and below	<input type="checkbox"/> \$18,090 and below	<input type="checkbox"/> \$21,105 and below
	<input type="checkbox"/> \$24,120 and above		
2	<input type="checkbox"/> \$20,300 and below	<input type="checkbox"/> \$24,360 and below	<input type="checkbox"/> \$28,420 and below
	<input type="checkbox"/> \$32,480 and above		
3	<input type="checkbox"/> \$25,525 and below	<input type="checkbox"/> \$30,630 and below	<input type="checkbox"/> \$35,735 and below
	<input type="checkbox"/> \$40,840 and above		
4	<input type="checkbox"/> \$30,750 and below	<input type="checkbox"/> \$36,900 and below	<input type="checkbox"/> \$43,050 and below
	<input type="checkbox"/> \$49,200 and above		
5	<input type="checkbox"/> \$35,975 and below	<input type="checkbox"/> \$43,170 and below	<input type="checkbox"/> \$50,365 and below
	<input type="checkbox"/> \$57,560 and above		
6	<input type="checkbox"/> \$41,200 and below	<input type="checkbox"/> \$49,440 and below	<input type="checkbox"/> \$57,680 and below
	<input type="checkbox"/> \$65,920 and above		
7	<input type="checkbox"/> \$46,425 and below	<input type="checkbox"/> \$55,710 and below	<input type="checkbox"/> \$64,995 and below
	<input type="checkbox"/> \$74,280 and above		
8	<input type="checkbox"/> \$51,650 and below	<input type="checkbox"/> \$61,980 and below	<input type="checkbox"/> \$72,310 and below
	<input type="checkbox"/> \$82,640 and above		
9	<input type="checkbox"/> \$56,875 and below	<input type="checkbox"/> \$68,250 and below	<input type="checkbox"/> \$79,625 and below
	<input type="checkbox"/> \$91,000 and above		
10	<input type="checkbox"/> \$62,100 and below	<input type="checkbox"/> \$74,520 and below	<input type="checkbox"/> \$86,940 and below
	<input type="checkbox"/> \$99,360 and above		

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