

FCHC Medical Care - PATIENT REGISTRATION FORM			TODAY'S DATE	PAGE 1
PLEASE COMPLETE IN BLACK INK				
LAST NAME		LEGAL FIRST NAME	MI	PREFERRED NAME if different than Legal Name
MAILING ADDRESS		CITY	STATE	ZIP
SOCIAL SECURITY NUMBER		DATE OF BIRTH	MARITAL STATUS	EMAIL ADDRESS
FCHC Medical Care, LLC is asking you to complete the next section to meet the requirements of Section 1557 of the Affordable Care Act. This is not specific to FCHC Medical Care, LLC, all healthcare facilities must comply.				
LEGAL SEX: <input type="checkbox"/> Female <input type="checkbox"/> Male	WHAT IS YOUR GENDER IDENTITY? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Other <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Decline to Answer		WHAT IS YOUR SEXUAL ORIENTATION? <input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual or Straight <input type="checkbox"/> Lesbian, Gay or Homosexual <input type="checkbox"/> Something Else <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Don't Know	
PREFERRED FORM OF COMMUNICATION FOR APPOINTMENT REMINDERS? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Text Message PREFERRED TIME TO CALL FOR APPOINTMENT REMINDERS? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening				
PHONE: HOME		MAY WE CONTACT YOU AT HOME? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: CELL		MAY WE CONTACT YOU ON YOUR CELL PHONE? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: WORK		MAY WE CONTACT YOU AT WORK? MAY WE LEAVE A NAME & CALL BACK NUMBER?	YES YES	NO NO
WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION? Information in your medical record is confidential and is protected under HIPAA/Ohio Laws. By completing this section and signing the Patient Registration Form consent, you are allowing our office to disclose your protected health information with the following:				
NAME		RELATIONSHIP	HOME PHONE	CELL PHONE
ETHNICITY (PLEASE CHECK ONE OF THE FOLLOWING) <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> DECLINE TO ANSWER		RACE (PLEASE CHECK ALL THAT APPLY) <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> DECLINE TO ANSWER		PRIMARY LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> ASL <input type="checkbox"/> OTHER
EMPLOYER NAME			OCCUPATION	
EMPLOYER ADDRESS		CITY	STATE	ZIP
IF PATIENT IS MARRIED PLEASE COMPLETE THE FOLLOWING INFORMATION				
SPOUSE'S INFORMATION				
LAST NAME		LEGAL FIRST NAME	MI	
MAILING ADDRESS		CITY	STATE	ZIP
SS#		DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME			EMPLOYER ADDRESS	
IF PATIENT IS A MINOR CHILD PLEASE COMPLETE THE FOLLOWING INFORMATION				
PARENT/GUARDIAN'S INFORMATION				
LAST NAME		LEGAL FIRST NAME	MI	
MAILING ADDRESS		CITY	STATE	ZIP
SS#		DATE OF BIRTH	OCCUPATION/	
EMPLOYER NAME			EMPLOYER ADDRESS	
PARENT/GUARDIAN'S INFORMATION				
LAST NAME		LEGAL FIRST NAME	MI	
MAILING ADDRESS		CITY	STATE	ZIP
SS#		DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME			EMPLOYER ADDRESS	

FCHC Medical Care - PATIENT REGISTRATION FORM			TODAY'S DATE	PAGE 2
PLEASE COMPLETE IN BLACK INK				
LAST NAME	LEGAL FIRST NAME	MI		
EMERGENCY CONTACT				
NAME		RELATIONSHIP	PHONE NUMBER	
MAILING ADDRESS	CITY	STATE	ZIP	
PRIMARY PHARMACY				
NAME			PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP	
IT IS THE PATIENT/GUARANTOR'S RESPONSIBILITY TO COMPLETE THE INSURANCE INFORMATION BELOW AND TO PROVIDE INSURANCE CARD(S) SO FCHC MEDICAL CARE, LCC CAN BILL YOUR INSURANCE APPROPRIATELY.				
PRIMARY INSURANCE COVERAGE – IF NO COVERAGE, PLEASE CHECK HERE <input type="checkbox"/>				
INSURANCE COMPANY NAME			GROUP NAME (EMPLOYER)	
I.D. NUMBER			GROUP NUMBER	
POLICY HOLDER NAME			RELATIONSHIP	
POLICY HOLDER'S SOCIAL SECURITY NUMBER			POLICY HOLDER'S DATE OF BIRTH	
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP	
INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY	
SECONDARY INSURANCE COVERAGE				
INSURANCE COMPANY NAME			GROUP NAME (EMPLOYER)	
I.D. NUMBER			GROUP NUMBER	
POLICY HOLDER NAME			RELATIONSHIP	
POLICY HOLDER'S SOCIAL SECURITY NUMBER			POLICY HOLDER'S DATE OF BIRTH	
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP	
INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY	
CONSENT TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS				
<p>I hereby consent to the use and disclosure by FCHC Medical Care, LLC of medical information to carry out medical treatment. Payment and health care operations as defined by applicable law. MEDICAL TREATMENT includes the provision, coordination and management of my health care and related services, including treatment by other health services and/or their agents to whom I may be referred (and any referring and primary care/family physician which have been or may be involved in my care and treatment). PAYMENT includes all activities relating to the determination of coverage and reimbursement for the provision of health care services and related claims management and review activities. HEALTH CARE OPERATIONS include activities of FCHC Medical Care, LLC relating to medical care and treatment and related assessment, quality improvement and management activities.</p> <p>I authorize the disclosure of my clinical health information for the duration of my care unless revoked in writing to those listed under WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION?</p> <p>I authorize my insurance benefit to be paid directly to FCHC Medical Care, LLC realizing that I am ultimately responsible for any allowable portion of the charge not covered by my insurance plans.</p>				
PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE			DATE	
X				
<p>If signed by patient's authorized representative, describe representative's authority:</p> <p><input type="checkbox"/> Patient is a minor; I am the patient's parent and natural guardian.</p> <p><input type="checkbox"/> Patient is a minor; I am the patient's guardian, appointed by the _____ County Juvenile Court.</p> <p><input type="checkbox"/> Patient is a ward; I am the patient's guardian, appointed by the _____ County Probate Court.</p> <p><input type="checkbox"/> I am the patient's attorney in fact, as designated in the patient's durable power of attorney for health care.</p>				
WITNESS SIGNATURE			DATE	