Patient Registration Form

Today's date: _________

Last Name:	First Name:	Middle name:

Date of Birth: _ _ / _ _/ _ _ _ _	Gender: ☐ Male ☐ Female ☐ Transgender, identifies as: M or F
School: (if applicable)	Primary Medical Doctor:

Address:	City:	State:	Zip:

Is this a temporary address? ☐ Yes ☐ No

Primary Phone: ( )	Other Phone: ( )

Emergency contact Information:

Last Name:	First name:	Phone:	Relationship to Patient:
		( )	

Your address and telephone number may be used by your healthcare team to contact you when needed to communicate important information to you. If you cannot be contacted due to confidentiality, you are asked to discuss this with the Bethel Health Center staff. Please arrange an alternative method of contact which would be used only when your health care necessitates it.

Primary language:	☐ English	☐ Spanish	☐ Other: ________________________
Language spoken at home:	☐ English	☐ Spanish	☐ Other: ________________________
Do you need an interpreter:	☐ Yes	☐ No	

Housing Situation- Check the item that best describes your household:

☐ Rent ☐ Own
☐ Homeless, living on street, camping, bridge, car
☐ Homeless shelter
☐ Doubling up
☐ Other: ___________________________________

Race and Ethnicity- Please check ALL that apply:

☐ Asian ☐ Alaska Native ☐ Native Hawaiian ☐ White ☐ Black ☐ American Indian ☐ Pacific Islander

Do you consider yourself to be Hispanic/Latino? ☐ Yes ☐ No

Responsible Party or Guarantor:

☐ **Self** If not, complete below:

Last Name:	First Name:	Relationship to Patient:

Address:	City:	State:	Zip:	Date of Birth:
				_ _/_ _/ _ _ _ _

The Bethel Health Center offers a sliding scale/discount program, and will not turn anyone away for inability to pay. If you need financial assistance, please check this box: ☐

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Patient name____

☐ No health Insurance	☐ Oregon Health Plan	☐ Private Insurance	
Primary Insurance company	Group Number:	ID#/Policy#:	Effective Date:
Insured Party:	Relationship to Patient:	Date of Birth:	Phone Number:

Assignment of Benefits/Insurance Release

I hereby authorize payment to be made directly to Bethel Health Center for all insurance benefits otherwise payable to me which I am entitled for medical, surgical, and/or hospital expenses. I understand I am financially responsible to the Bethel Health Center for charges not covered by my insurance benefits and that I am directly responsible for payment for all charges regardless of insurance coverage. I hereby authorize Bethel Health Center to furnish my Insurance Company(s) all information which said Insurance Company(s) may request and/or require concerning my illness(es) and/or injury(s) including psychiatric, drug, alcohol abuse, acquired immunodeficiency syndrome, thus releasing Bethel Health Center from any liability for furnishing such information.

Fees

I understand that Bethel Health Center clients will be asked to pay a fee depending on service provided each visit. However, no Bethel Health Center client will be turned away for inability to pay.

____ ________________________

Patient/Parent/Legal Guardian Signature **Date**

Please initial all boxes

☐ **Consent To Treat**

I hereby consent to receive health services, including medical, dental, mental health, surgery, regular and emergency services, as determined to be in the best interest of myself, my child or legal charge, if I am the parent or legal guardian. This authorization shall continue to be in full effect until revoked in writing or client no longer eligible for services. Consent to treat is renewable annually.

☐ **Receipt of Rights and Responsibilities**

I acknowledge that I have received a copy of Bethel Health Center's Rights and Responsibilities.

☐ **Notice of Privacy Practices**

I acknowledge that I have received a copy of Bethel Health Center's Privacy Practices.

☐ **Acknowledgement of Mandatory Reporting**

I understand that Bethel Health Center are required by law to report any unsafe situation to Child Welfare or law enforcement.

____ ____________________

Patient/Parent/Legal Guardian Signature **Date**

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