PATIENT REGISTRATION FORM

Please call or text (540) 464-8700, or ask a Patient Access Representative for help with filling out forms.

This form registers me for all services. I'm interested in: ❒ Medical ❒ Dental ❒ Behavioral Health ❒ Family Planning

Patient's Full Legal Name

Last Name	First Name	Middle Name
Date of Birth	Social Security Number	
Gender ❒Male ❒Female ❒Unknown	Marital Status ❒Single ❒Married ❒Divorced ❒Widowed	
Mailing Address		
City	State	Zip Code
Physical Address (if different than mailing)		
House Phone	Cell Phone	Work Phone

If we are unable to contact you and you have voicemail, do we have your permission to leave a message? ❒ Yes ❒ No

Email address: ______________________________@___________________

Patients with email addresses listed on this registration form will automatically be registered with our patient portal which can be accessed by visiting our website www.rockahc.org. You can request medication refills, view lab results and more.

For minors:

Is there a custody order on file? ❒Yes ❒No If yes, please provide a current custody order. Note: a parent or legal guardian **must** be present at the first visit.

Employment Information

Are you employed? ❒Full-time ❒ Part-time ❒ Self-Employed ❒ Retired ❒Not Employed	Name of Employer		
Employer Address	City	State	Zip Code
Are you a student? ❒Full-time ❒Part-time ❒Not a Student			

Financial Responsibility (For minor patients, it is the parent/legal guardian completing this form.)

❒Self (Skip to next section if checked here) ❒Parent ❒Legal Custodian ❒Guardian/Power of Attorney

Last Name	First Name		
Date of Birth	Social Security Number	Home Phone	
Address ❒Same as above	City	State	Zip Code

What is the estimated total annual household income before taxes, including wages and disability?

❒Under $11,000 ❒ $15,001- $20,000 ❒ $25,001- $35,000 ❒ $45,001- $55,000 ❒ Choose not to disclose

❒ $11,001- $15,000 ❒ $20,001- $25,000 ❒ $35,001- $45,000 ❒ Over $55,000

How many people are living in your home, including yourself? _________

RAHC offers additional savings based on household size and income to uninsured and insured patients. If the income is under this amount per year before anything is taken out, please complete the **Application for the Sliding Fee Discount**.

1 person= $24,280 2 people= $32,920 3 people= $41,560 4 people= $50,200 5 people= $58,840 6 people= $67,480

**Limits are higher for Family Planning Services*

Pharmacy

Name of Preferred Pharmacy: ___________________________________

If left blank, all prescriptions will go to Lexington Prescription Center, where patients receive the biggest discount.

Provider Information

Are you transferring medical care to RAHC? ❒ Yes ❒ No If yes, from which practice?

Are you transferring dental care to RAHC? ❒ Yes ❒ No If yes, from which practice?

List other health care professionals involved in your care:

Do you have an advanced directive ❒ Yes ❒ No

If yes, your clinical team would like to have a copy on file. We have sample advanced directives if you don't have one.

Medical Insurance

Do you have medical insurance ❒ Yes ❒ No If yes, insurance company name: ________________________

Plan ID Number	Plan Group Number	
Policy Holder Name	Date of Birth	Social Security Number
Policy Holder Address		Phone Number

Do you have secondary health insurance ❒Yes ❒No If yes, insurance company name: ________________________

Plan ID Number	Plan Group Number	
Policy Holder Name	Date of Birth	Social Security Number
Policy Holder Address		Phone Number

Dental Insurance

Do you have dental insurance ❒ Yes ❒ No If yes, insurance company name: ________________________

Plan ID Number	Plan Group Number	
Policy Holder Name	Date of Birth	Social Security Number
Policy Holder Address		Phone Number
Dental Benefits Phone Number on Card		

Additional Patient Information

We collect information on our patients to help us know more about the community we serve and to improve our services. We report this information without identifying patients personally. *For example, we report that we serve 100 veterans.*

Veteran Status: Have you ever been in the Armed Forces of the United States? ❒ Yes ❒ No

Are you active duty military? ❒ Yes ❒ No

Race: ❒ Asian ❒ White ❒ Black or African American ❒ Pacific Islander

❒ American Indian or Alaskan Native ❒ Other race ❒ Unreported/refused to report

Ethnicity: ❒ Hispanic or Latin American ❒ Non-Hispanic ❒ Unreported/refused to report

Preferred Language: ______________________ Do you require assistance with language interpretation? ❒Yes ❒No

Sexual Orientation:

❒Lesbian or Gay ❒Straight ❒Bisexual ❒Something else ❒ Don't know ❒ Choose Not to Disclose

Gender Identity :

❒Male ❒Female ❒Transgender Male (Female to Male) ❒Transgender Female (Male to Female)

❒ Genderqueer (neither exclusively male or female) ❒ Choose Not to Disclose ❒ Other

Residence: Are you a seasonal resident? ❒ Yes ❒ No Do you live in public housing? ❒ Yes ❒ No

Are you a migrant worker? ❒ Yes ❒ No Are you homeless? ❒ Yes ❒ No

Are you living in a multi-family home? ❒ Yes ❒ No

Privacy Information

Government **HIPAA** (**Health Insurance Portability and Accountability Act of 1996**) regulations require permission from the patient in order for any healthcare professional to speak with family, friends or caregivers regarding your protected health information, except in cases of emergency. RAHC is serious about the responsibility of keeping your medical and account information private and confidential. The RAHC's full Notice of Privacy Practices can be viewed online at www.rockahc.org or by requesting a copy at the Front Office.

In order for us to share any of your information, we must have written permission. We have your permission to talk to the following people about **general scheduling, medical, account/financial information.**

Name of Emergency Contact #1	Permission to discuss ❒ Medical ❒ Financial
Home or Cell Phone Number	Relationship to Patient
Name of Emergency Contact #2	Permission to discuss ❒ Medical ❒ Financial
Home or Cell Phone Number	Relationship to Patient

Signature

I understand that by signing this document, I attest to the accuracy of the information provided. I also understand that if the information changes, I will contact RAHC. (For minor patients, parent/legal guardian completing this form sign below.)

Signature	Print Name
Relationship to patient	Date