

PATIENT REGISTRATION FORM



PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ Email Address _____

Phone _____ Cell Home Work

How would you like to receive appointment reminders? Text Phone Call

RESPONSIBLE PARTY (Who is responsible for payment for services (after insurance)?)

Self Parent/Guardian Other (Specify Relationship): _____

Please complete the information below if you did not mark "self" as the responsible party:

First Name _____ MI _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ Email Address _____

Phone _____ Cell Home Work

EMERGENCY CONTACT

First Name _____ Last Name _____

Relationship to Patient _____

Phone _____ Cell Home Work

DEMOGRAPHIC INFORMATION

Sex: Male Female

Race: Black/African American White American Indian/Alaska Native
 More than one race Asian (please specify) _____
 Native Hawaiian/Other Pacific Islander (please specify) _____

Ethnicity:

Puerto Rican Cuban Mexican, Mexican American, Chicano
 Combination Another Hispanic, Latino, or Spanish Origin
 Not Hispanic, Latino, or Spanish

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DEMOGRAPHIC INFORMATION CONTINUED

Do you need any language interpretation services?

No Yes (specify language): _____

What is your primary MEDICAL insurance?

I do not have medical insurance Medicare Medicaid Medicaid Expansion
 Other Private or Public Insurance (specify): _____

Are you a U.S. veteran?

Yes No

At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?

Yes- Seasonal work Yes- Migrant work No

What is your current housing situation?

I have housing

I do not have housing. I am

- Doubling up (Staying with others)
- In a transitional shelter
- In a homeless shelter
- On the street

Is your annual household income above the Federal Poverty Guidelines?

Yes No Unsure

If you answered "Yes", you do not need to fill out the following questions.

If you answered "No" or "Unsure", fill out the following questions to see if you qualify for reduced fees on your bill with Northland Health Centers.

How many individuals are in your household? (Including yourself)

**What is your household's total combined income for a 1-year period?
(Before taxes and deductions)**

Northland Health Centers has a program that offers all patients reduced fees based on household income and size. This program is available to all patients regardless of insurance status and is called the "Northland Cares" program.

Would you like a Northland Cares application to see if you qualify for reduced fees?

Yes No