HAWSE HEALTH CENTERS
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle:	Birth Date:	Sex: ☐ Male ☐ Female	Social Security Number:

PO Box:	Street: City: State: Zip Code

Parent/Guardian Name: If Patient is a minor, mother's maiden name:	Home Phone# _____ Cell Phone# _____ **Best Daytime Phone#_____**	Parent/Guardian Date of Birth:	Parent/Guardian Social Security#
Street Address: PO Box:	City:	State:	Zip Code:

Marital Status: Single☐; Married☐; Divorced☐; Separated☐; Widow☐
Race: White☐; Black/African American☐; American Indian/Alaskan Native☐; Asian☐; Native Hawaiian/Other Pacific Islander☐; Other☐; Declined☐
Ethnic Origin: Hispanic or Latino☐; Not of Hispanic or Latino Origin☐; Declined☐;
Language: English☐; Spanish☐; Other☐_____
Sexual Orientation: Straight☐; Bisexual☐; Lesbian or gay☐; Something Else ☐; Don't know ☐; Chose not to disclose ☐
Gender Identification: Male☐; Female☐; Transgendered Male/Female☐; Transgendered Female/Male☐; Declined☐; Other☐_____
Veteran Status: Veteran☐; Active Duty☐; None☐
Homeless Status: Homeless Shelter☐; Transitional☐; Doubling Up☐; Street☐; Not Homeless☐; Other☐; Declined☐
Poverty Level: Unknown☐; <=100%☐; 101-150%☐; 151-200%☐; >200%☐
Worker Status: Migrant☐; Seasonal☐; Retired☐; Student☐; Declined☐; Unemployed☐
Employed☐; **Employer/Phone# _____**

Email: _____

Pharmacy of choice: _____

IF WE ARE UNABLE TO CONTACT YOU, WHO SHOULD WE CALL:

Name: _____Phone# _____Relationship to Patient: _____

Name: _____Phone# _____Relationship to Patient:_____

INSURANCE INFORMATION

(Please give your insurance cards to the receptionist)

Is this patient covered by insurance? ☐Yes ☐No	Name of Primary Insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth Date:	Group no:	ID no:	Co-Payment: $
Subscriber's Address:				Home Phone: ( )	
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Name of Secondary insurance (if applicable):	Subscribers name:	Group no:	ID no:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to E. A. Hawse Health Center. I understand that I am financially responsible for any unpaid balance. I also authorize E. A. Hawse Health Center to release any information required to process my insurance claim. I authorize E. A. Hawse Health Center's Medical, Dental, Behavioral Health staff to consult together and to perform needed treatments and/or diagnostic tests for necessary care including Medical, Dental or Behavioral Health services.

_____ _____

Patient/Guardian Signature *Date*

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Updated 8/8/2016
Updated 8/13/18
Updated 7/16/2019