BCFWC-PATIENT REGISTRATION FORM

Patient Information

First Name_____

Last Name_____

Address_____

_____

City _____

State _____ Zip_____

***E**mail **A**ddress* _____

Soc **S**ec # _____

Birth Date_____/_____/_____
month day year

Phone # _____

Parent or Guardian

Name_____ SSN_____

Phone #_____

Date of Birth_____

Relationship to Patient _____

Emergency Contact

Name_____

Address_____

City, State, Zip_____

Phone # _____

Relationship to Patient**:** _____

Please Circle

Gender: Male Female Transgender Male/Female-to-Male Transgender Female/Male-to-Female Other
Chose not to disclose

Sexual **O**rientation: Lesbian or Gay Straight (not lesbian or gay) Bisexual Something Else Don't Know
Chose not to disclose

Language: English Spanish Other: _____

Race: Black/African American Hispanic/Latino Asian Native Hawaiian Other Pacific Islander
American Indian/Alaska Native White More than one race Unreported/Refused to report race

Marital **S**tatus Single Married Other _____ (please list) Chose not to disclose

Smoker Yes No **V**eteran Yes No **S**tudent Yes No

Child (ren) Name for Appointment

Child One

First Name _____ Soc Sec **#** _____

Last Name_____ Birth Date _____/_____/_____
month day year

Please Circle

Gender: Male Female Transgender Male/Female-to-Male Transgender Female/Male-to-Female Other
Chose not to disclose

Sexual Orientation: Lesbian or Gay Straight (not lesbian or gay) Bisexual Something Else Don't Know
Chose not to disclose

Language: English Spanish Other: _____

Race: Black/African American Hispanic/Latino Asian Native Hawaiian Other Pacific Islander
American Indian/Alaska Native White More than one race Unreported/Refused to report race

Assignment and Release

I hereby consent to all treatment deemed necessary by the medical staff of BCFWC. I authorize the release of any information necessary to process this claim. I request that any money due me for medical benefits to be assigned to BCFWC. I realize that I am responsible for any and all differences. I have received the Notice of Privacy Practices and I agree to pay my fee at the time of service. I further attest that as of the date of my signature, the income sources listed constitute all my household income, and that the family members listed are all solely dependent on that income or that the explanation provided to verify my income level is truthful.

Patient Signature X_____ **Date** _____

Child Two

First Name _____ Soc Sec **#** _____

Last Name_____ Birth Date _____/_____/_____
month day year

Please Circle

Gender: Male Female Transgender Male/Female-to-Male Transgender Female/Male-to-Female Other
Chose not to disclose

Sexual Orientation: Lesbian or Gay Straight (not lesbian or gay) Bisexual Something Else Don't Know
Chose not to disclose

Language: English Spanish Other: _____

Race: Black/African American Hispanic/Latino Asian Native Hawaiian Other Pacific Islander
American Indian/Alaska Native White More than one race Unreported/Refused to report race

Child Three

First Name _____ Soc Sec **#** _____

Last Name_____ Birth Date _____/_____/_____
month day year

Please Circle

Gender: Male Female Transgender Male/Female-to-Male Transgender Female/Male-to-Female Other
Chose not to disclose

Sexual Orientation: Lesbian or Gay Straight (not lesbian or gay) Bisexual Something Else Don't Know
Chose not to disclose

Language: English Spanish Other: _____

Race: Black/African American Hispanic/Latino Asian Native Hawaiian Other Pacific Islander
American Indian/Alaska Native White More than one race Unreported/Refused to report race

Child Four

First Name _____ Soc Sec **#** _____

Last Name_____ Birth Date _____/_____/_____
month day year

Please Circle

Gender: Male Female Transgender Male/Female-to-Male Transgender Female/Male-to-Female Other
Chose not to disclose

Sexual Orientation: Lesbian or Gay Straight (not lesbian or gay) Bisexual Something Else Don't Know
Chose not to disclose

Language: English Spanish Other: _____

Race: Black/African American Hispanic/Latino Asian Native Hawaiian Other Pacific Islander
American Indian/Alaska Native White More than one race Unreported/Refused to report race

Insurance Confirmation (Insured Patient Only)

Insurance Card Scanned into System Yes_____ No_____ or Medicaid Pending _____

Income/Social Verification (sliding scale patients only) Billing Department

Check Stub Copied and attached? Yes _____ No _____ Monthly earnings_____

# of family members_____

If check stub is not copied and attached, please check the applicable reason below:

_____First time visit/unaware of requirements (1 day limit)

_____Non-compliant spouse regarding income proof (1 year limit)

_____Unaccompanied minor, no proof available (1 year limit)

_____No income, completed free visit verification for free visit (1 day limit)

_____Proof is filed under another patient's account number (Expiration the same as patient with proof filed)

Proof filed under account number: _____

If none of the above choices replicable and no proof of income is available for an uninsured patient, an explanation for determining eligibility may be provided and initiated below by the Financial Counselor at the time of application:

_____Sliding scale per supervisor approval-see notes below for explanation (1 year limit)

_____

_____

_____

Supervisor initials_____

Financial Class Determination (all patients)

Fee for Service Insurance Medicaid_____ Medicare_____ Commercial_____

HMO-Assigned to BCFWC Medicaid_____ Medicare_____ Commercial_____

Harmony_____ First Health Network_____

Self-pay

Free care
Effective dates_____to_____

Registration initials and date_____