St.Jude Neighborhood Health with Providence | St.Joseph Neighborhood Health with Providence | St.Mary Neighborhood Health with Providence

Patient Registration

Through our faith-based centers, we improve the health and well-being of low-income persons in the communities we serve. Thank you for choosing us as your healthcare provider. For efficient registration, please complete ALL questions on this form. If it does not apply mark N/A.

Last Name:	**First Name:**
Middle Name:	**Other Names/Alias:**
Social Security #: - - □ N/A	**Date of Birth:**
Mailing Address:	**City:** **State:** **Zip:**
Email Address:	
Phone Number(s): (Please mark preferred contact number) □ Home: □ Cell: □ Work:	
Preferred Language: □ English □ Spanish □ Other:	**Interpreter Needed:** □ No □ Yes
Sex Assigned at Birth: □ Female □ Male	
Sexual Orientation: □ Straight/Heterosexual (attracted exclusively to people of the other sex) □ Bi-sexual □ Lesbian/Gay □ Choose not to disclose □ Don't know □ Other:	
Gender Identity: □ Female □ Male □ Transgender Female (male to female) □ Transgender Male (female to male) □ Choose not to disclose □ Other:	
Marital Status: ☐ Single ☐ Married ☐ Widow/er ☐ Separated ☐ Divorced ☐ Domestic Partner	
Deaf/Hard of Hearing: □ No □ Yes	**Blind/Low Vision:** □ No □ Yes **Speech Impaired:** □ No □ Yes

Ethnicity (Select One):	**Race (Choose all that Apply):**	
□ Cuban	□ Asian Indian	□ Other Pacific Islander
□ Mexican, Mexican American, Chicano	□ Chinese	□ Guamanian or Chamorro
□ Not Hispanic, Latino, or Spanish origin	□ Filipino	□ Samoan
□ Puerto Rican	□ Japanese	□ Black or African American
□ Another Hispanic, Latino, or Spanish origin	□ Korean	□ American Indian/Alaska Native
□ Choose not to disclose	□ Vietnamese	□ White
☐ Unknown	□ Other Asian	□ Choose not to disclose
	□ Native Hawaiian	

Patient Employment Status: □ Full-time □ Part-time □ Student full-time □ Student part-time □ Disabled □ Active Military □ Retired □ Self-employed □ Not Employed

Religion:	**Do you have Health Insurance:** □ No □ Yes
Primary Care Physician PCP:	

Insurance Carrier Name and ID #:	
If Under 18, Who is Financially Responsible for You (Guarantor): Name: _____ Date of Birth: _____ Mother's Name: _____ Father's Name: _____	**Emergency Contact Person:** Name: _____ Relationship: _____ Phone #: _____ Address: _____ City: _____ State: ____ Zip: _____

Advance Directives

Are you interested in information on establishing Advance Directives?
An Advanced Directive is a document describing your wishes regarding medical treatment, often including a living will, that is used if/when you cannot communicate your wishes to a doctor because of an injury or illness.
□ Yes □ No

Grant Data Information **St. Jude Neighborhood Health, receives grants that support our work. The grant(s) require us to collect the following information, therefore it is required to be answered.*

Household Size (Including yourself, how many individuals live in your household who are related to you by birth, marriage, or are claimed as tax dependents?):	
Monthly Salary: $ _____	**Other Monthly Income:** $ _____
At any time this year, did you stay in a shelter, transitional housing, on a friend's sofa, or on the street due to homelessness?	□ Yes □ No
Have you served in the United States military, armed forces, or uniformed services?	□ Yes □ No
Are you or anyone in your family an agriculture worker?	□ Yes □ No

Sign and date this form and return it to the front desk. Thank you.
The above information is true to the best of my knowledge. I request and authorize St. Jude Neighborhood Health to provide me with health care services. I understand that St. Jude Neighborhood Health may use and disclose my information as described in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices. I have reviewed and agree to comply with the St. Jude Neighborhood Health patient contract. I acknowledge St. Jude Neighborhood Health receives HHS funding and has Federal Public Health Service deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and for its covered individuals. I understand that I will never be denied care due to an inability to pay and that I may qualify for reduced fees based on my household income. **I understand and agree to notify St. Jude Neighborhood Health if any of the information on this form should change while I am under their care.**

_____ _____
Signature **Date**

OFFICE USE ONLY:
Clinic Rep. Initials _____ Date Reviewed _____

Date Received: ______________________

Financial Screening (only complete this section if you do NOT have health insurance):

Last Name:	First Name:	MRN:

Income Sources	Amounts
Salary & Wage (before deductions)	
Self-Employment Income	
Interest & Dividends	
Real Estate Rental/Lease Income	
Social Security Benefits	
Alimony/Child Support	
Unemployment/Disability	
Other	
Total:	**$**

Answer the Questions for Each Family Member – (Use N/A if it does not apply):

First Name:	**Last Name:**	
Does this person want to be considered for our reduced fee program? □ Yes □ No		
Date of Birth:	**Age:**	**Social Security #:** - -
Relationship to You:	**Monthly Income:**	**Income Source/Employer:**

First Name:	**Last Name:**	
Does this person want to be considered for our reduced fee program? □ Yes □ No		
Date of Birth:	**Age:**	**Social Security #:** - -
Relationship to You:	**Monthly Income:**	**Income Source/Employer:**

First Name:	**Last Name:**	
Does this person want to be considered for our reduced fee program? □ Yes □ No		
Date of Birth:	**Age:**	**Social Security #:** - -
Relationship to You:	**Monthly Income:**	**Income Source/Employer:**

First Name:		Last Name:
Does this person want to be considered for our reduced fee program? □ Yes □ No		
Date of Birth:	**Age:**	**Social Security #:** - -
Relationship to You:	**Monthly Income:**	**Income Source/Employer:**

To qualify for discounts on your fees, you must attach the following proof of income:

□ Tax Return for most recent year (must include W2s) for everyone in household
□ Copies of information on any health insurance coverage anyone in the house might have
□ Proof of address (Government ID or bill mailed to your home address)

If you don't have a tax return:

□ Two recent paystubs (include any SSI, alimony, or child support payments) for anyone receiving income in the household
□ Two recent bank statements for everyone in the household with a bank account

I attest that the above information is true to the best of my knowledge. I understand that I must notify St. Jude Neighborhood Health if my insurance status or income changes.

_____ _____

Signature Date

CAREGIVER'S AUTHORIZATION AFFIDAVIT

If you are unable to bring your child to their appointment, the following information will be used to allow family or friends to bring your child in without you being present.

We, the parents of _____, give permission to the following adults (must be 18 years of age or older) to bring our child to their appointment at your facility.

ID will be required to be shown by the individual bringing the child in on the day of the appointment.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand that if none of the above adults are available to bring my child in for their appointment, I will need to reschedule the appointment.

Parent Signature: _____ Date: _____