HOT SPRINGS HEALTH PROGRAM
Hot Springs Medical Center
Laurel Medical Center
Mashburn Medical Center
Mars Hill Medical Center

PATIENT REGISTRATION

Office Use Only
FD–Info Updated _____(initials)
FD–Form Scanned/Attached _____(initials)
Date patient contacted:_____
Date patient contacted:_____
Date Inc Lvl entered in PP:_____

Name:_____ _____ _____ **Date of Birth**:____/____/____
First Middle Initial Last

Social Security #:_____ **Sex (M/F)**:_____ **Marital Status (S/M/D/W)**:_____ **Veteran**: ___Yes ___No

Mailing Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Home Phone:_____ **Work Phone**:_____ **Cell Phone**:_____

Email:_____ **Preferred Language:** ☐ English ☐ Spanish ☐ Other:_____

For patient's under 18 years of age: Mother's Name:_____ Father's Name:_____

Legal Guardian (if applicable):_____ **Person Responsible for Payment**:_____

Preferred Method of Contact: ☐Mail ☐Phone ☐Portal

Person to contact in case of emergency: Name:_____

Relationship:_____ Home #:_____ Cell #:_____ Work #:_____

Primary Insurance Information

Insurance Co. Name:_____ **ID#**:_____ Group#_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Sex:_____

Relationship to Policy Holder:_____ Employer Name:_____

*TriCare – Sponsor's SSN:_____

Secondary Insurance Information

Insurance Co. Name:_____ **ID#**:_____ Group#_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Sex:_____

Relationship to Policy Holder:_____ Employer Name:_____

*TriCare – Sponsor's SSN:_____

Third Insurance Information

Insurance Co. Name:_____ **ID#**:_____ Group#_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Sex:_____

Relationship to Policy Holder:_____ Employer Name:_____

*TriCare – Sponsor's SSN:_____

The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against patients seeking care from organizations receiving USDA funding. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way. However, if you choose not to furnish it, we are required to note the race/national origin of the individual patient on the basis of visual observation or surname.

☐ I do not wish to furnish this information.

ETHNICITY: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Data used by HSHP (a Federally Qualified Health Center Look-Alike) in determining potential qualification for Sliding Fee Discount and other assistance programs as well as reporting. *If not completed, you will not be eligible for potential discount.* Someone will discuss with you your potential qualification today or contact you within one (1) week.

☐ I do not wish to furnish this information. ☐ Medicaid is my primary insurance.

Number of Persons in Home (circle one): 1 2 3 4 5 6 7 8 9 10 Other:_____

Household Income Range (circle one): < $12,880 $12,880-17,130 $17,131-25,760 $25,761-34,840 $34,841-43,920 $43,921-53,000 $53,001-62,080 $62,081-71,160 $71,161-80,240 $80,241-89,320 $89,321+