

Office Use Only

FD–Info Updated (initials)

FD–Form Scanned/Attached (initials)

**PATIENT REGISTRATION**

**Hot Springs Medical Center**

**Laurel Medical Center**

**Mashburn Medical Center**

**Mars Hill Medical Center**

**Today’s Date:**

**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:** EnglishSpanishOther:

***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 Responsible Date of Birth:**

**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:

**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

**The following information is requested by the U.S. Health Resources & Services Administration (HRSA)** to promote culturally competent outcomes and reduce health disparities. This information will not be used to discriminate against you in any way.

I do not wish to furnish this information.

SEXUAL ORIENTATION:  Heterosexual (or straight)  Lesbian or Gay  Bisexual  Something else

GENDER IDENTITY: Male/Man Female/Woman Transgender Man/Male (Female-to-Male) Transgender Woman/Female (Male-to-Female) Other

Within the last 24 months, have you or your parents (if patient is a minor) worked in AGRICULTURE either on a farm or at an agricultural based industry?  Yes  No

If yes, which applies?  Year Round Employment (permanent residence in area)  Migrant  Seasonal  Other

Type of HOUSING for patient or patient’s parent/guardian if a minor:  Rent/Own home  Public Housing  Homeless Shelter

Transitional (live place to place)  Doubling Up (live with another person or family)  Street  Permanent Supportive housing

Other

**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 a 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

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

Household Income Range (circle one): <= $14,580 $14,581-19,720 $19,721-24,860 $24,861-30,000 $30,001-35,140 $35,141-40,280 $40,281-45,420 $45,421-50,560 $50,561-53,572 $53,573-60,409 $60,410-67,245 $67,246-75,851

$75,852-84,435 $84,436-90,840 $90,841-101,120 $101,121+

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