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)

Today's Date: _____

Patient Information only in this box

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

Social Security #: _____ **Sex (M/F)**: _____ **Marital Status (S/M/D/W)**: _____
Mailing Address: _____
City: _____ **State**: _____ **Zip Code**: _____
Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____
Email: _____ **Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____

For patients under 18 years of age

Parent/Guardian 1 Name: _____ _____ _____ **Date of Birth**: ____/____/____
Parent/Guardian 1 Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Parent/Guardian 1 Email Address: _____ **Parent/Guardian 1 Cell:** _____

Parent/Guardian 2 Name: _____ _____ _____ **Date of Birth**: ____/____/____
Parent/Guardian 2 Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Parent/Guardian 2 Email Address: _____ **Parent/Guardian 2 Cell:** _____

Person Responsible for Payment: _____ **Person Responsible Date of Birth:** _____

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: _____

Have you served in the United States military, armed forces or uniformed services? (this includes: Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves or the US Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA):

☐ Yes ☐ No

Federal Government requests the following information 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

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 two (2) weeks.

☐ 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**): <= $15,960 $15,961-21,640 $21,641-27,320 $27,321-33,000 $33,001-38,680 $38,681-44,360 $44,361-50,040 $50,041-55,720 $55,721-58,999 $59,000-66,553 $66,554-74,108 $74,109-83,567 $83,568-93,052 $93,053-100,080 $100,081-111,440 $111,441+