AVENUE360 HEALTH + WELLNESS

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Last Name:	First Name:	Date of Birth: / /	Preferred Name:

Home Address:	Apt. #:	City:	State:	Zip Code:	County:

Preferred Phone: ☐ Home ☐ Cell	Alternate Phone: ☐ Home ☐ Cell	Social Security #:

Name of Partner or Spouse:	Email Address:	Mother's Maiden Name:

Marital Status (Check One):
☐ Single ☐ Married ☐ Life Partner
☐ Divorced ☐ Separated ☐ Widowed
☐ Unknown ☐ Legally Separated

What is your current work situation:
☐ Unemployed
☐ Part-time ☐ Full-time
☐ Choose not to disclose or decline to answer

Are you currently enrolled in school?
☐ Part-time ☐ Full-time
☐ Not enrolled
☐ Choose not to disclose or decline to answer

Primary Language: ☐ English ☐ Spanish ☐ Other: _____ **Do you need a translator?** ☐ Yes ☐ No

DEMOGRAPHIC INFORMATION

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unknown/Refuse to Report

Are you of Hispanic origin? ☐ Yes ☐ No
If Hispanic, check ethnicity origin: ☐ Mexican/Mexican American/Chicano(a) ☐ Puerto Rican ☐ Another Hispanic, Latino(a) or Spanish Origin ☐ Cuban ☐ Unknown/Refuse to Report

Are you homeless? ☐ Yes ☐ No **If homeless:** ☐ Homeless Shelter ☐ Transitional Living Facility ☐ Doubling Up ☐ Street

Do you reside in a Public Housing facility? ☐ Yes ☐ No **Do you have an Advanced Directive?** ☐ Yes ☐ No

Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? (if served) What area, the Armed Forces, Reserves, or National Guard did you serve? (If your answer is no, please skip the next two questions)
☐ No ☐ Yes, in the Armed Forces ☐ Yes, in the Reserves ☐ Yes, in the National Guard ☐ Refused ☐ Don't Know

Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? (if active) What area, the Armed Forces, Reserves, or National Guard?
☐ No ☐ Yes, in the Armed Forces ☐ Yes, in the Reserves ☐ Yes, in the National Guard ☐ Refused ☐ Don't Know

Have you ever been deployed to a combat zone? ☐ Never Deployed ☐ Iran/Afghanistan (OEF/OIF/OND)
☐ Persian Gulf (Operation Desert Shield/Desert Storm) ☐ Vietnam/Southeast Asia, Korea ☐ WWII
☐ Deployed to a combat zone not listed above (e.g., Bosnia/Somalia) ☐ Refused ☐ Don't Know

SEXUAL ORIENTATION AND GENDER IDENTITY

What sex were you assigned on your original birth certificate?
☐ Male ☐ Female ☐ Choose not to disclose

What are your preferred pronouns?
☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:_____

Do you think of yourself as (Check One): ☐ Straight or heterosexual ☐ Gay, lesbian or homosexual ☐ Bisexual or pansexual
☐ Asexual or something else ☐ Questioning or don't know ☐ Choose not to disclose or decline to answer

To better serve you, what is your current gender identity? (Check One) ☐ Male ☐ Female
☐ Transgender Male/Trans Man/Female-to-Male (FTM) ☐ Transgender Female/Trans Woman/Male-to-Female (MTF)
☐ Additional Gender Category/Other, please specify:_____ ☐ Choose not to disclose or decline to answer

EMERGENCY CONTACT INFORMATION / DELEGATED INDIVIDUAL FOR COMMUNCIATION (Delegated individual for communication is the patient-appointed person to communicate with about your healthcare, which may include information about your diagnosis, eligibility status and appointments.)

Name of Emergency Contact:	Phone Number of Emergency Contact:	Relationship to Patient:
Name of Delegated Individual for Communication:	Phone Number of Delegated Individual:	Relationship to Patient:

HOW DID YOU HEAR ABOUT US?

☐ Flyer ☐ Relative/Friend ☐ Church ☐ School ☐ Event/Fair ☐ Walk-In ☐ Hospital
☐ 2-1-1 ☐ Newspaper ☐ Radio ☐ Internet ☐ Magazine ☐ TV ☐ Eligibility Worker
☐ Other: _____

Social Media: ☐ Email ☐ Twitter ☐ Instagram ☐ Facebook ☐ Other: _____

PREFERRED PHARMACY INFORMATION

Name of Preferred Pharmacy:	Preferred Pharmacy Intersections:	Preferred Pharmacy Phone Number:

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Registration Staff Signature:_____ **Date:**_____

AVENUE360 HEALTH + WELLNESS

INCOME AND INSURANCE INFORMATION

Last Name:	First Name:	MI:	Date of Birth: / /

PAYMENT POLICY

- Payment of co-pays and certain other fees are expected at time of service.
- Uninsured patients are also expected to pay appropriate fees at time of service.
- It is your responsibility to notify Avenue 360 Health and Wellness of any insurance carrier changes.
- If you have either Medicaid and/or Medicare the charges for your visit and the services received will be submitted to Medicaid and/or Medicare for reimbursement to the clinic.
- If you have submitted an application for Medicaid and/or Medicare you will be responsible for the full amount of the charges until your application is approved.

INSURANCE INFORMATION

Is this patient covered by the Insurance being presented. ☐ Yes ☐ No (If you checked "No" please skip this section).

The insurance being presented is coverage for: (Check one that applies): ☐ Medical ☐ Dental ☐ Both

Please indicate primary insurance: ☐ Private ☐ Medicaid ☐ Medicare ☐ CHIP ☐ CHIP Perinatal
☐ Other:_____

Secondary insurance, if applicable: ☐ Private ☐ Medicaid ☐ Medicare ☐ CHIP ☐ CHIP Perinatal
☐ Other:_____

Person responsible for charges:

Name	Address	Phone Number

Insurance Plan	Policy Number	Group Number

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

GROSS INCOME

Monthly gross income (Please enter income earned before taxes are deducted):	Household size:

Please check one that applies:

☐ I am employed but unable to provide proper documentation of income, my income per month on average is approximately..... $_____

☐ I am self-employed, my income per month on average is approximately..... $_____

☐ I am unemployed, no one supports me, my income per month on average is approximately..... $_____

DISCOUNT FEE PROGRAM

- I understand that Avenue 360 Health and Wellness offers a sliding fee schedule to discount the cost of medical or dental care for individuals and families that meet financial eligibility criteria. It is my responsibility to provide Avenue 360 Health and Wellness with the appropriate financial documentation requested to determine my eligibility for this discount program.
- I understand that I must re-apply for the discount program each year, or sooner if my household income or family size changes.
- I attest that the information provided on this form is accurate and any findings by Avenue 360 of false statements may result in full payment of all rendered and future costs.

I HAVE READ AND UNDERSTOOD THE PAYMENT OPTIONS OF THE POLICY.

_____ _____
Patient/Parent/Guardian Signature Date

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Registration Staff Signature:_____ **Date:**_____