SWMTCHC ANNUAL PATIENT REGISTRATION FORM

PATIENT INFORMATION				**Date**
LAST NAME	FIRST NAME		MIDDLE INITIAL	PREFERRED NAME
DATE OF BIRTH	SS #	Email:		
		Would you like to sign up for MyChart? ☐ Yes ☐ No		

PATIENT CONTACT INFORMATION			
MAILING ADDRESS	City	State	Zip
PHYSICAL ADDRESS (if different than mailing address)	City	State	Zip

HOME PHONE	CELL PHONE	WORK PHONE
PREFERRED COMMUNICATION FOR REMINDERS	☐ Text ☐ Phone/Voicemail ☐ MyChart ☐ Please Do Not Contact	

EMERGENCY CONTACT INFORMATION		
PRIMARY CONTACT (LAST NAME, FIRST NAME)	PHONE NUMBER	
ADDRESS, CITY, STATE, ZIP ☐same as patient	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ Yes ☐ No
SECONDARY CONTACT (LAST NAME, FIRST NAME)	PHONE NUMBER	
ADDRESS, CITY, STATE, ZIP ☐same as patient	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (if different than patient)				
LAST NAME	FIRST NAME		INITIAL	PREFERRED NAME
DATE OF BIRTH	SS #	RELATIONSHIP	PHONE	
ADDRESS	City		State	Zip

EMPLOYMENT STATUS

☐ Child ☐ Full-time ☐ Part-time ☐ Not employed ☐ Active military duty ☐ Retired ☐ Seasonal
☐ Self-employed ☐ Student ☐ Unemployed due to disability ☐ Choose not to disclose

EMPLOYED BY:

HOUSING STATUS

Have you **remained** in a safe and stable housing environment for the past year? ☐ Yes ☐ No

IF NO: ☐ Transitional house ☐ Living with others ☐ Shelter ☐ Street/camp/bridge ☐ Other:

Are you in public housing? ☐ Yes ☐ No	Are you an agricultural migrant or seasonal worker? ☐ Migrant ☐ Neither ☐ Seasonal

OVER→

ADDITIONAL PATIENT INFORMATION--We are an inclusive healthcare center--this information matters to your treatment	
LEGAL SEX	☐ Female ☐ Male ☐ Nonbinary ☐ Unknown ☐ X
GENDER IDENTITY	☐ Female ☐ Male ☐ Transgender Female/M→F ☐ Transgender Male/F→M ☐ Non-binary/genderqueer ☐ Other ☐ Questioning ☐ Two spirit ☐ Choose not to disclose
SEX ASSIGNED AT BIRTH	☐ Female ☐ Male ☐ Unknown ☐ Not recorded on birth certificate ☐ Intersex ☐ Choose not to disclose
SEXUALITY/SEXUAL ORIENTATION	☐ Straight or Heterosexual ☐ Gay ☐ Asexual ☐ Bisexual ☐ Lesbian ☐ Omnisexual ☐ Pansexual ☐ Queer ☐ Something else ☐ Don't know ☐ Choose not to disclose
PRONOUNS	☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ey/em/eirs ☐ ve/vir/vis ☐ xe/xem/xyrs ☐ ze/hir/hirs ☐ Other ☐ Patient's name ☐ Unknown ☐ Choose not to disclose
MARITAL STATUS	☐ Divorced ☐ Domestic Partner ☐ Legally separated ☐ Married ☐ Other ☐ Significant other ☐ Single ☐ Widowed ☐ Choose not to disclose
ETHNICITY	☐ Cuban ☐ Mexican, Mexican American, or Chicano/a ☐ Puerto Rican ☐ Another Hispanic or Latino/a ☐ Non-Hispanic or Non-Latino/a ☐ Unknown ☐ Choose not to disclose
RACE (MARK ALL THAT APPLY)	☐Alaskan Native ☐American Indian ☐Asian Indian ☐Black/African American ☐Chinese ☐Filipino ☐Guamanian or Chamorro ☐Japanese ☐Korean ☐Native Hawaiian ☐Other Asian ☐Other Pacific Islander ☐White/Caucasian ☐Other/Unknown ☐Choose not to disclose
VETERAN and MILITARY STATUS	☐ Active duty ☐ Inactive duty ☐ No previous experience ☐ Reservist ☐ Veteran ☐ Choose not to disclose
	Dates of service, if applicable: START END

PATIENT ASSISTANCE AND ACCOMMODATION

Are you visually impaired? ☐ **Yes** ☐ **No** **Are you hearing impaired?** ☐ **Yes** ☐ **No**

Are any additional accommodations or assistance required? (please list below):

Preferred language (if not English):	Do you need an interpreter? ☐ Yes ☐ No

AUTHORIZATION AND ASSIGNMENT

I hereby consent to the rendering of such care, including routine diagnostic procedures and such medical treatment and dental care as my provider and other health care staff of the Southwest Montana Community Health Center (SWMTCHC) considers necessary. I understand that the practice of health care/dental care is not an exact science, and that diagnosis and treatment may involve risk, injury, or even death. I acknowledge that no guarantees have been made to me as the result of examination or treatment.

I understand that:

a) It is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until they have had an opportunity to discuss them with the provider or other with the provider or other health professional to the patient's satisfaction.

b) Each patient has the right to consent or to refuse consent to any proposed procedure or therapeutic course; and

c) No patient will be involved in any research or experimental procedure without their full knowledge and consent.

I understand that I am responsible for the cost of my care and that payment is expected at the time of service unless other arrangements have been made. I understand that I am responsible for charges that my insurance (including private insurance, Medicaid, Medicare, or any other third-party payor) does not pay. Services will not be denied based on ability to pay; however, I understand that refusal to pay balance owed could result in the denial of any non-emergent services by the SWMTCHC.

I hereby give consent for the treatment as necessary. I also authorize the SWMTCHC to release information required to process this claim. I hereby assign my insurance benefits to be paid directly to SWMTCHC and if my financial situation changes, I will report those changes to the SWMTCHC.

I understand that my charges may be reduced, depending on my income, based on a sliding fee scale. Because of this, I promise to furnish accurate household income and size information to the SWMTCHC and if my financial situation changes, I will report those changes to the SWMTCHC.

I do hereby give consent to have my picture obtained for electronic health record use only. I understand that if I do not wish to give my consent, I will still receive full health care services (as eligible) by SWMTCHC.

I have had an opportunity to ask any/all questions, and I am satisfied that I understand its contents and significance.

PATIENT SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SIGNATURE (if patient is a minor) _____ DATE _____