Patient Registration Form

Date ____ /____/ _____

How did you hear about us?

- ☐ Family/Friend
- ☐ Internet Search
- ☐ Case Manager
- ☐ Medical Provider
- ☐ Social Media
- ☐ Advertisement
- ☐ Other

PATIENT INFORMATION (PLEASE PRESENT YOUR PHOTO IDENTIFICATION AND INSURANCE CARD WITH THIS PAPERWORK)

☐Mr. ☐Ms. ☐Mrs. ☐Dr. ☐Miss ☐Mx. Legal Name: First Middle Last Suffix (Jr, Sr, II, III, etc.)

Affirmed Name/Nickname

Birth Date Mon Day Year _____ /_____/ _____

Are you - the patient - responsible for all bills and insurance? _____

If not, please list the name of the responsible person. _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Street Address Apt/Ste/Unit City State Zip

Mobile/Cell Phone ( ) Home Phone ( ) Email Address

Best way to contact me or leave messages (check all that apply):

☐ Phone/Voicemail ☐ Text ☐ E-Mail ☐ U.S. Mail

Gender Listed on Insurance or Driver's License

☐Male ☐Female ☐Non-Binary

Social Security Number _____ -_____- _____

Occupation Employer Work Phone

Emergency Contact Phone Relationship to Patient

INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK STAFF MEMBER

Legal Name of Person Responsible for Bill ☐ Same as Above Relationship to Patient if Patient is not Responsible Party

Birth Date (if the patient is not responsible party) _____ /_____/_____

Social Sec Number of Responsible Party _____ -_____- _____

Street Address (if different) City State Zip

Email Address Home Phone ( ) Cell Phone ( ) Work Phone ( )

Primary Insurance Company Subscriber's Name ID# Group#

Secondary Insurance Company Subscriber's Name ID# Group#

Patient Registration Form

INCOME: (PLEASE GIVE VERIFICATION OF INCOME TO A PATIENT REPRESENTATIVE IF APPLYING FOR SLIDING FEE or RYAN WHITE GRANT FUNDS)

Annual Income: $ _____ Household Annual income: $ _____

Number of adults in household (including you): _____Number of children in household (under 18 years old): _____

AR Health receives funding to provide financial benefits to patients. By providing your proof of income, AR Health can determine whether you are eligible for these benefits. Proof of your income includes, but is not limited to, your last two to three pay stubs, last year's W-2 form, or last year's tax return.

By signing, I understand that I may be eligible for the AR Health sliding scale or Ryan White financial benefits based on my income. However, I must provide proof of income to receive these benefits. I understand that I will be charged the full fee of my visit if I do not bring in income documentation by my third visit or within 60 days of my first visit, whichever comes first. I understand that I will never be refused services at AR Health because I do not provide documentation of income.

Patient Signature_____Date_____/_____/ _____

DISCLAIMER STATEMENT

I authorize AR Health to submit claims to my insurance carrier and to release any medical information necessary to process all claims. I also authorize payment for any medical benefits to AR Health for all services provided until further notified for this account. I agree that I am financially responsible for any co-pay and self-pay balance at the time of service, and any balance that may be due after the claims have been

Patient Signature _____ Date_____

Office use only:

- ☐ All documents signed
- ☐ ID scanned
- ☐ Insurance scanned
- ☐ Correct insurance information entered
- ☐ Affirmed name entered

Office Staff Initials: _____

Demographics Form

Name on ID/Insurance: First	Middle	Last	New Patient? ☐ Yes ☐ No
Chosen First Name:	Birth Date: Month / Day / Year		

Have you attended AIDS Resource outreach events? ☐ Yes ☐ No
Do you receive public benefits (SNAP, Access (medical card), etc.)? ☐ Yes ☐ No

Pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Only my name ☐ No preference ☐ A pronoun not listed

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these questions were provided by our funders; we understand that current demographic categories do not adequately capture our individual identities. Please help us serve you better by selecting the best answers to these questions. Thank you.

Preferred Spoken and Written Language:
- ☐ English
- ☐ Spanish
- ☐ American Sign Language
- ☐ Other: _____

Language Interpretation Services Needed?
- ☐ No
- ☐ Yes Language: _____

Ethnicity:
- ☐ Hispanic/Latinx
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other
- ☐ Not Hispanic/Latinx
- ☐ Decline to Answer

Race: Select up to two*
- ☐ African
- ☐ Black American
- ☐ White/Caucasian
- ☐ Asian
- ☐ Asian American
- ☐ Native American
- ☐ Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Decline to Answer
- ☐ Other (please specify): _____

Housing Status:
- ☐ Permanent Housing
- ☐ Non-Permanent Housing
- ☐ Institution
- ☐ Unhoused
- ☐ Transitional Shelter
- ☐ Doubling Up (not paying rent)
- ☐ Couch Surfing
- ☐ Other
- ☐ Decline to Answer

Sexual Orientation:
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Straight
- ☐ Questioning
- ☐ Decline to Answer
- ☐ Something Else

Sex Assigned at Birth:
- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Decline to Answer

Completed Level of Education:
- ☐ 1-8 Years
- ☐ High School Degree
- ☐ GED
- ☐ Trade School
- ☐ Some College
- ☐ Associate's College Degree
- ☐ Bachelor's College Degree
- ☐ Master's Degree
- ☐ Doctorate Degree
- ☐ Decline to Answer

Income (if applying for sliding scale fees)

Anticipated annual household income for this year: _____

Total # people living in household, including you: _____

I verify that the above information is correct to the best of my knowledge.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Parent/Guardian Signature if patient is under 18 Date