Blue Ridge MEDICAL CENTER

# PATIENT REGISTRATION FORM

**DATE:**_____

Registration is for ☐ Medical (BRMC) ☐ Dental (BRDC) ☐ Behavioral Health

| **PATIENT INFORMATION** | | | | |
|---|---|---|---|---|
| Last Name | First Name | | | Middle Initial |
| Mailing Address | | City | State | Zip |
| Home phone | Cell Phone | Work Phone | | |
| Date of Birth (mm/dd/yyyy) _ _/_ _/ _ _ _ _ | Age | Gender at Birth ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other | |
| | Language: English ☐ Spanish ☐ Other ☐ | | Will you need an interpreter? ☐ Yes ☐ No | |
| LEmployment ☐ Full-Time ☐ Part-time ☐ Retired ☐ Student ☐ Other _____ | | | Working Status ☐ Migrant ☐ Seasonal ☐ Neither | |
| Employer Name | Employer Address | | | |
| | City | State | Zip | |

| **IN CASE OF EMERGENCY** | | | |
|---|---|---|---|
| Emergency contact person's name | Relationship to Patient | | |
| Address | City | State | Zip |
| Primary Phone | Secondary Phone | Other Phone | |

| **RESPONSIBLE PARTY (GUARANTOR)** | | | |
|---|---|---|---|
| Guarantor's Last Name | First Name | | Middle Initial |
| Mailing Address (If different from patient) | City | State | Zip |
| Guarantor's Phone Number | | Date of Birth ( mm/dd/yyyy) __ __/__ __/ __ __ __ __ | |

| **INSURANCE INFORMATION** | | |
|---|---|---|
| Name of primary medical insurance | Policy subscriber's name, if not patient | Policy subscriber's Date of Birth |
| Name of dental insurance | Policy subscriber's name, if not patient | Policy subscriber's Date of Birth |
| Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify _____ | | |

| **CONTACTING YOU** |
|---|
| Tell us where to call you, leave you messages and appointment reminders: ___Home ___Cell___Work |
| Can BRMC/BRDC leave messages on the phone numbers you have provided? ☐ Yes ☐ No If yes, may we leave:<br>Brief messages with no clinical information, *OR* ☐ Yes ☐ No<br>Extended messages with some clinical information ☐ Yes ☐ No } *Please choose one* |
| E-mail address(We will not share this with any other entities) |

**As a medical center that receives some federal funding, the following information will help us tailor our services to better meet your needs and to obtain grants and other funds to continue improving our practice. *THANK YOU* in advance for your assistance.**

RACE (check all that apply): ☐ White ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other (specify) _____ ☐ Decline to state ☐ Unknown

ETHNICITY:

Blue Ridge MEDICAL CENTER

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**DATE:**_____

| | |
|---|---|
| ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown | |
| HOUSING: ☐ Single Family ☐ Multi-Family ☐ Apartment ☐ Other | |
| LIVING SITUATION: ☐ Homeless Shelter ☐ Street ☐ Doubling Up (sharing space) ☐ Transitional ☐ Other ☐ Unknown | Are you a veteran of the US Armed Forces? ☐ Yes ☐ No |
| Household size: _____ Annual household income: (please check the appropriate range)<br>☐ $0 - $50,000 ☐ $50,001 - $100,000 ☐ $100,001 or above ☐ Decline to state | |
| Sexual Orientation: ☐ Lesbian or Gay, ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose | |
| Do you identify your gender as: ☐ Male, ☐ Female, ☐ Transgender Male to Female, ☐ Transgender Female to Male, ☐ Other, ☐ Choose not to disclose | |
| | |
| Do you have an Advance Directive on file with our office? ☐ Yes ☐ No | |
| Would you like information about Advance Directives? ☐ Yes ☐ No | |

| **Pharmacy Selection** | |
|---|---|
| ☐ Blue Ridge Medical Center Pharmacy ☐ Other | |
| **Please read the items below and initial beside each item, then sign and date as noted.** | **Initial below** |
| **PRIVACY PRACTICE:** I have read and understand the BRMC/BRDC "Notice of Privacy Practices." | |
| **MEDICAL RECORDS:** I give permission to BRMC/BRDC to obtain medical records from any provider, practice or pharmacy where I have received services in order to optimize my care. | |
| **NO SHOW:** I understand that there is a policy in place for patients who fail to arrive for their appointments. In the event that I do not contact BRMC/BRDC at least 24 hours in advance of my appointment to cancel or reschedule I understand that BRMC/BRDC can take action up to and including dismissing me from the practice | |
| **INSURANCE:** I authorize BRMC/BRDC to furnish information to my insurance company regarding my health or healthcare or dental care. I assign BRMC/BRDC to receive payment from insurance claims filed by BRMC/BRDC for medical/dental services. I understand that I am responsible for the payment of all fees and that I am ultimately responsible for making sure my insurance will cover appointments with BRMC/BRDC and with specialists to whom I am referred by BRMC/BRDC. | |
| **PATIENT PAYMENT RESPONSIBILITY:** I understand that I am responsible for payment for services received at BRMC/BRDC, whether full fee, nominal fee or sliding scale. Insured patients acknowledge responsibility for co-pays, deductibles and co-insurance payments. *All unpaid balances are subject to collections fees.* | |
| **AUTHORIZATION TO TREAT:** I Authorize BRMC/BRDC to treat me for the conditions for which I present to the center. | |

**Patient/Guardian Signature** _____ **Date** _____

**Please remember to have your insurance card and co-payment ready at check in.**
**The Front Desk representative will take your photograph so that we can accurately identify you at each visit.**
**The photo is for internal use only.**

**How did you hear about BRMC/BRDC?** ☐ Family/friend ☐ Newspaper ☐ Radio/TV/Billboard ☐ Social Media ☐ Internet Search ☐ Other (specify) _____

| **FOR OFFICE USE ONLY** | | | | | |
|---|---|---|---|---|---|
| **Entered** ☐ Yes ☐ No | Date: | Initial | **Scanned** ☐ Yes ☐ No | Date: | Initial |