ANNUAL PATIENT REGISTRATION FORM

Note: ***This application expires on December 31st of each year. A new application must be submitted annually.***

A. PATIENT'S PERSONAL INFORMATION

Patient's Legal Name: _____ Name Used: _____

Address: _____ Date of Birth: MM/DD/YYYY

City: _____ State: _____ Zip: _____ Primary Phone: _____

Email: _____ Secondary Phone: _____

Preferred Language Spoken: _____ Do you need an interpreter? ☐ YES ☐ NO

Mother's Maiden Name: _____ (required for Indiana Vaccine Registry)

SEX ASSIGNED AT BIRTH	GENDER IDENTITY	PRONOUNS	RACE	ETHNICITY	IMMIGRATION STATUS
☐ Male ☐ Female	☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other:	☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:	☐ White ☐ Black / African American ☐ Asian ☐ Other:	☐ Hispanic/Latino ☐ Not Hispanic / Not Latino	☐ Immigrant ☐ Migrant Worker ☐ Refugee ☐ Asylee ☐ Other:

If Patient is a minor or an incapacitated adult, please complete below: (attach supporting documentation)

Parent/Legal Guardian's Name: _____ Primary Phone: _____

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Durable Power of Attorney ☐ Other: _____

B. CONTACT INFORMATION

Emergency Contact: _____ Primary Phone: _____

Relationship to Patient: _____

C. PATIENT'S HEALTH INSURANCE INFORMATION

1. Does the patient have any state or federally funded health insurance coverage? ☐ YES ☐ NO
   If YES, please select one of the following: ☐ Medicare ☐ Medicaid / Healthy Indiana Plan (HIP) ☐ Tricare

2. Does the patient have private health insurance coverage? ☐ YES ☐ NO
   If YES, please provide your insurance card(s) to our associate to copy.

Primary Insurance Company Name: _____

Policyholder's Name: _____ Policyholder's Date of Birth: MM/DD/YYYY

Insured's Relationship to Patient: _____ Preferred Phone: _____

Insured's Address: _____
Address City State Zip

FOR OFFICE USE ONLY: ACCOUNT #: _____

PLEASE CONTINUE TO OTHER SIDE

D. SLIDING FEE DISCOUNT PROGRAM APPLICATION

Would you like to apply for our Sliding Fee Discount Program? ☐ YES (Please continue below) ☐ NO (Sign below)

Signature (if declining): _____

**If income information is not received within the 10 days requested, the visit may be subject to full fee.*

Please list all family members currently living in the household, *including the Patient: (ask for another paper if more than 6.)*

Family Member Name(s):	Date of Birth (Month/Day/Year)	Relationship to Applicant
1. Patient:		
2.		
3.		
4.		
5.		
6.		

E. EMPLOYMENT STATUS

Employed	Self-Employed		
☐ Full-time	☐ Full-time	☐ Unemployed	☐ Other:
☐ Part-time	☐ Part-time	☐ Disabled	
☐ Temporary	☐ Temporary	☐ Retired	
		☐ Veteran	

F. SELF / FAMILY INCOME INFORMATION

Total Family Yearly Income: ☐ $ 0 - $12,000 ☐ $12,001 - $15,000 ☐ $15,001 - $ 18,000 ☐ $18,001 - $21,000 ☐ $21,001 - $24,000 ☐ More than $24,000 ☐ I decline to provide income.

G. AUTHORIZATIONS

☐ I authorize any bank or financial institution, government agency or department, hospital, physician, corporation or individual to furnish any information concerning this application to any authorized agent of Shalom Health Care Center.

☐ I authorize Shalom Health Care Center to release any information regarding services rendered by any provider to my health insurance company and, in case of Medicare, to the Centers of Medicare and Medicaid Services and its agents; and allow a photocopy of my signature to be used to file insurance, including Medicare, when applicable. I request that payment, including Medicare authorized benefits, be made on my behalf to Shalom Health Care Center. Regardless of my health insurance benefits, if any, I understand I am financially responsible for the fees for covered services and any costs incurred. I further understand that if my account is turned over to a collection agency, I will be responsible for any interest charges allowed at the current legal rate, collection fees, reasonable attorney fees and court cost.

☐ I affirm that ***I am not a relative*** of a current Shalom employee, if so please provide employee name below.

Relative/Employee Name: _____

I acknowledge my full understanding of the above stated and affirm that the information I have provided is true and correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: MM/DD/YYYY

Thank you for choosing Shalom Health Care Center as your Patient Centered Medical Home.