BETANCES HEALTH CENTER

Patient Registration Form

Last Name:	**First Name:**	**Middle Int.:**	**Preferred Name:**
Date of Birth:	**Age:**	**Social Security #:**	**Preferred Language:**
Street Address:		**Home #:**	
		Cell #:	
City:	**State:**	**Zip Code:**	**E-mail:**

If patient is under 18, please provide guardian's Information:

Last Name:	**First Name:**	**Relation to patient:**
Street Address:		**Home #:**
		Cell #:
City:	**State:**	**Zip Code:** **E-mail:**

Would you like to access your medical records via the internet/Patient Portal? ☐ **Yes, Please provide e-mail above** ☐ **No**

Gender Assigned at Birth: ***(Choose One)***

☐ **Male** ☐ **Female**

Relationship Status: (*Choose One)*

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Gender Identity: (*Choose One)*

☐ **Male**	☐ **Female**		
☐ **Transgender Male (Female – to – Male)**	☐ **Transgender Female (Male – to – Female)**		
☐ **Other**			
☐ **Choose not to disclose**			

Sexual Orientation: (*Choose One)*

☐ **Lesbian or Gay**	☐ **Straight**		
☐ **Bisexual**	☐ **Something Else**		
☐ **Don't Know**			
☐ **Choose not to disclose**			

Race: (*Choose All That Apply)*

☐ **American Indian or Alaskan Native**	☐ **Asian**	☐ **Black or African American**	☐ **Native Hawaiian**
☐ **Other Pacific Islander**	☐ **White**	☐ **Unreported/Refuse to report race**	

Ethnicity: (*Choose One)*

☐ **Hispanic or Latino** ☐ **Non-Hispanic or Non-Latino** ☐ **Refuse to report Ethnicity**

Is there anyone else you would authorize to bring the child and discuss patient information with and make clinical decisions on my behalf? **If none, check this box** ☐

Last Name:	**First Name:**	**Relation to patient:**
Last Name:	**First Name:**	**Relation to patient:**

Please turn over to complete the registration form									
In case of an emergency, who can we contact?									
Last Name:	**First Name:**	**Relation to patient:**							
Home #:		**Cell #:**							
Preferred Pharmacy Information:					**If none, check this box**				
Name:		**Telephone #:**							
Address:		**Fax #:**							
Financial Information: ***Betances is a Federally funded organization who must capture the financial status of its patients to continue to receive funding. PLEASE ANSWER ALL THE QUESTIONS BELOW.***									
Are you employed? (*Check One)*		**Yes**		**No**	**Do you have insurance?**		**Yes**		**No**
Are you the Head of Household? (*Check One)*		**Yes**		**No**	**# of Dependents (Include yourself as 1)**				
What is the household income? (Write in and circle one)	**$**		**Bi-Weekly**		**Monthly**		**Annually**		

Financial Policy:

This information is to provide clarification for patients of Betances Health Center regarding matters of insurance, co-pay, deductibles, and co-insurance amounts due at the time of service. Betances Health Center has an obligation to various Healthcare plans to apply any deductible and/or collect any co-payment prior to provision of services.

Co-Pays: You will be required to pay your co-payment upon arrival for your appointment.

Deductibles and Co-Insurance: You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit.

Previous Balance: You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or to answer any questions regarding your bill, please contact our Billing Department at 212-227-8401.

For your convenience, we accept most insurances as well as cash, credit cards, checks and money orders. If you have medical insurance, we will bill the insurance for maximum allowable benefits; however, you remain responsible for payment if your claim is rejected. Personal checks are not accepted for the first time visit. Returned checks will be charged a $30.00 handling fee. Payments not received within 90 days will be sent to collection.

Please sign the Acknowledgement Below:

I acknowledge that the above information is true and accurate demographic information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier of services described. I have also read that above financial policy and agree to the terms of the policy.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____