Primary: _____ Dental: _____ Prenatal: _____ **Patient Registration Form (*2 pages*)** New □ Annual □

Home Location: ☐ Families First ☐ HH ☐ Goodwin Community Health ☐ Lilac City Pediatrics

PATIENT:

Name: _____ Date of Birth: _____/_____/_____ Gender (at time of birth): ☐ M ☐ F

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Okay to leave a voicemail? ☐ Yes ☐ No

Cell Phone: (_____) _____ Okay to leave a voicemail? ☐ Yes ☐ No Okay to text you? ☐ Yes ☐ No

Email Address: _____ (Patient portal access available upon request)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐White ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐American Indian ☐More than one race ☐Other_____

Veteran Status: ☐Veteran ☐Non-Veteran U.S Citizen ☐Yes ☐No

Agricultural Work Status: ☐ Non-Agricultural ☐ Seasonal ☐ Migrant ☐ Employed year-round ☐ Retired Farmworker

Gender Identity: ☐ M ☐ F ☐ Female to Male ☐ Male to Female ☐ Genderqueer ☐ Other _____ ☐ Choose not to disclose

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Their/Theirs ☐ Other _____

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Something else _____ ☐ Don't know ☐ Choose not to disclose

Living Arrangements: ☐ Rent ☐ Own ☐ Stay w/relatives/friends ☐ Shelter ☐ Other temporary housing _____

Language: _____ Are you Deaf? ☐ Yes ☐ No *An interpreter can be provided during care upon request*

PARENT / GUARDIAN: (Complete if patient is under 18 years old)

1.) Name: _____ Date of Birth: _____/_____/_____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: ☐ Mother ☐ Father Other (please fill in): _____ Sex: ☐ M ☐ F

2.) Name: _____ Date of Birth: _____/_____/_____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: ☐ Mother ☐ Father Other (please fill in): _____ Sex: ☐ M ☐ F

EMERGENCY CONTACT: (In an emergent situation, the person listed below will be made aware that you are receiving care at our facility)

Name: _____ Relationship: _____ Phone: (_____)_____

Preferred Local Hospital: _____ Ok to speak to regarding ☐ Medical Care ☐Appointments

*COVERAGE MAY REQUIRE NOTIFYING THE INSURANCE CARRIER OF YOUR PROVIDER. THIS IS THE RESPONSIBILITY OF THE PATIENT. _____(Initials)

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Relationship to Patient: _____

Secondary/ Dental Insurance Name: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Relationship to Patient: _____

Employer providing insurance coverage: _____

1. How did you hear about us? _____ (New Patients only)
2. Are you transferring your care from another medical or dental office? ☐ Yes ☐ No If yes, where?_____

Patient / Guardian Signature: X _____ Date: _____ (OVER) -->

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

FINANCIAL DETERMINATION

HQ T'Q HHKEG'WUG'/RCVKGPV'PQVKHECVKQP"
☐ CRRTQXCN"" ☐ FGPKCN""
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Gzrktgu<'aaaaaaaaaaaa"

Greater Seacoast Community Health offers a discount based on income for patients who are uninsured, or whose insurance doesn't cover certain services (such as dental or behavioral health care).

IF YOU DO NOT WISH TO APPLY: Please provide the information and signature requested below. This helps us meet the requirements of the state and federal grants we receive. Family size:_____ Annual household income: $_____

☐ I do not wish to apply for the sliding fee discount. Patient/guardian signature: _____ Date: _____

TO APPLY FOR THE SLIDING FEE DISCOUNT: Please fill in the table below and supply proof of income within the next 30 days. Discounts are based on family size and household income. We will tell you what your sliding fee category and discount are, and you will be eligible for this discount for one year. (After one year, you will be asked to submit proof of income again.)

Examples of *types* of income:
- Social Security
- Retirement
- Business
- Welfare payments
- Child support
- Alimony
- Disability
- Others

Examples of *proofs* of income:
- 4 weeks of current and consecutive pay stubs
- Current tax return
- 4 weeks of unemployment check stubs

Please provide the information requested below for yourself and all persons living with you.

Name (First, MI, Last)	Sex	Relationship to you	Date of Birth	Income and Frequency	Income Type
		SELF		$	
				$	
				$	
				$	
				$	
Family Size:			Household Income:	$	

The above information supplied is current and accurate to the best of my knowledge. I understand that if information provided is found to be inaccurate, any discount given may be reversed.

Patient/Guardian Signature X_____Date:_____

☐ I would like a free appointment to understand the insurance options available to me.

Q HHKEG'WUG'Q PN[<"

Approved Date: _____	❒ Category 1	❒ Category 2	❒ Category 3	❒ Category 4	❒ Full Pay
Usual Medical Fee:	❒ $30	❒ 40%	❒ 60%	❒ 80%	❒ Full Pay
Basic Dental Payments:	❒ $40	❒ 50%	❒ 65%	❒ 80%	❒ Full Pay
Major Dental Payments:	❒ $40+	❒ 60%	❒ 75%	❒ 90%	❒ Full Pay

Based on POI of $_____ ❒ monthly ❒ annually ❒ refused

Staff Name: _____ Date: _____

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ecvgiqt{"fktgevu{'qp'vjg'kpeqo g"*wdlgev'vq'cffkkqpcn'tgxkgy+0

Please PRINT the patient's name clearly: _____

PLEASE READ CAREFULLY! SIGNATURES ARE REQUIRED BELOW BEFORE YOU MAY BECOME A PATIENT.

WE WILL ASK FOR YOUR SIGNATURE EVERY TWELVE MONTHS.

The Foundation for Seacoast Health: Community Campus — Safe Campus Restrictions

In order to keep children and others on the community campus safe, our landlord, (The Foundation for Seacoast Health) will not allow on the Campus people who fall into the following categories:

People who have been determined to be a sexual offender as defined by RSA 651-B,
People who have been determined to be an offender against children as defined by RSA 651-B,
Individuals who may pose a risk to the safety of others.

The Foundation for Seacoast Health is requiring that Families First take steps to make sure that people who fall into the above three categories are not coming to the Community Campus.

By signing this form, I agree to the following:

If Families First determines in its own judgment that I fall into any of the three categories listed above:
I will be immediately discharged from Families First, and will not receive any more services;
I will immediately leave the Community Campus and will not return;
Families First will immediately release my name and address to the Foundation for Seacoast Health; and
I will hold neither Families First nor the Foundations for Seacoast Health responsible for the release of my name and address to the Foundation for Seacoast Health.

The Foundation for Seacoast Health may prohibit me from coming to the Community Campus if it is determined that I fall into any of the three categories listed above.

_____ _____

Signature **Date**

I hereby give permission for Families First Health Center to examine and conduct such referrals, tests and procedures as are needed for my diagnosis and care, and to give such treatment as the health center's providers deem necessary. I understand that Families First, medical and support staff, may disclose and use this information for treatment, including sharing this information with other providers to provide continuity of care.

I hereby authorize release of PHI (Personal Health Information) necessary to file a claim and audit with my insurance company and assign benefits to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier, including, but not limited to, deductible and co-payments. At the end of sixty days, billing is my responsibility. A copy of this signature is valid as the original. The information I have provided is accurate and complete to the best of my ability.

_____ _____

Signature **Date**

I acknowledge that I have read and understand the following documents: Health Center Patient Compact, Notice of Information Practices (Summary), Consent to Use and Disclose Health Information, "Safe Campus" Policy, Late Policy and **Health Insurance/PCP responsibility**. You may see these policies in Part II of the Patient Handbook, or on our website.

_____ _____

Signature **Date**

If you have MEDICARE coverage you must sign below.

I request that payment of authorized Medicare benefits be made to Families First of the Greater Seacoast for services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. (This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service Families First provides to the beneficiary during his/her lifetime, unless revoked.)

Print Name of Beneficiary: _____ Medicare # _____

Signature of Beneficiary or Representative: _____ Date: _____