RURAL HEALTH, Inc.
We specialize in you

Initial _____

PATIENT REGISTRATION FORM

Please provide a driver's license or picture identification card, along with current insurance cards and any copay due at time of service

Last Name:_____First Name:_____

First name used: _____ Middle name, suffix_____

Previous Name (last, first):_____

Legal Sex: ( ) Male ( ) Female Date of Birth: ____/____/_____

Social Security Number:_____ Mother's maiden name:_____

Email:_____@_____

Access to Patient Portal: [ ] Yes [ ] No

Patient Home Address:_____

Mailing Address:_____

City_____State_____Zip_____

Driver's License Number:_____State_____Expiration Date_____

Patient Phone: Home ( )_____-_____ Cell ( ) _____-_____ Work ( ) _____- _____

Consent to text [ ] Yes [ ] No

Contact preference: [ ] Home [ ] Cell [ ] Work [ ] Mail [ ] Portal

Pharmacy:_____ Address:_____City_____State_____

Pharmacy Phone:( )_____-_____

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*For Data Collections Purposes Only; Rural Health, Inc. is required to report the following data for all patients. Rural Health, Inc. reports this information **anonymously** and the information you provide will not affect your payment amount.*

Language spoken (mark all that apply)

[ ]English [ ]Spanish [ ]Other_____ [ ] Decline to Disclose

Interpreter Status Do you require an interpreter? [ ]Yes [ ]No

Race [ ]Asian [ ]American Indian [ ]Black/African-American [ ]Native-Hawaiian [ ]White [ ]More than one race [ ]Other Pacific Islander [ ] Other_____ [ ] Decline to Disclose

Patient Name:_____Date of Birth:_____

Ethnicity [ ]Hispanic or Latino [ ]Not Hispanic or Latino [ ]Declined to Disclose

Marital Status [ ]Unknown [ ]Married [ ]Single [ ]Divorced [ ]Separated [ ]Widowed [ ]Partner

Sexual Orientation [ ]Lesbian gay or homosexual [ ]Straight or heterosexual [ ]Don't know [ ]Bisexual [ ]Something else, please describe_____ [ ]Choose not to disclose

Gender Identity [ ]Identify as a Male [ ]Identify as a Female [ ]Choose not to disclose [ ]Transgender Male/Female-to-Male (FTM) [ ]Transgender Female/Male-to-Female (MTF) [ ]Gender non-conforming (neither exclusively male or female) [ ]Additional gender category/other/please specify_____

Assigned sex at birth [ ]Male [ ]Female [ ]Choose not to disclose [ ]Unknown

Pronouns [ ]he/him [ ]she/her [ ]they/them

Homebound [ ]Yes [ ]No
Homebound if defined as; needing help of another person or medical equipment such as crutches, a walker, or a wheelchair to leave your home, or your doctor believes that your health or illness could get worse if you leave your home.

Agricultural Worker [ ]Yes [ ]No [ ]Patient Declined *Migrant/Seasonal Status
[ ] Migrant *(A person/dependent whose principle employment has been in agriculture within The 24 months and has had to establish a temporary home for the purpose of such employment)*
[ ] Seasonal *(A person/dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment)*

Homeless Status [ ]Yes [ ]No [ ] Patient Declined [ ]Doubling up [ ]Homeless Shelter [ ]Street [ ]Transitional [ ]Other [ ]Unknown

Veteran Status [ ]Yes [ ]No [ ]Patient Declined

Housing Status [ ]Public Housing [ ]Not in Public Housing [ ]Patient Declined

How did you hear about us? [ ]Advertising [ ]Primary Care Physician [ ] Specialist Physician [ ]Word of Mouth [ ]Patient in the Practice [ ]Hospital [ ]Insurance Company [ ]Existing Patient [ ]Other please specify if other_____

Patient Name:_____Date of Birth:_____

Employer Information

Patient's Employer_____

Address_____

City_____State_____Zip_____

Phone Number_____Occupation:_____

Employment Status: [ ]Full Time [ ]Part Time [ ]Retired [ ]Student [ ]Other

Emergency Contact

Name: _____

Relationship to Patient: _____Emergency Contact Number: ( )_____- _____

Next of Kin

Name:_____Relationship:_____ Phone: ( )_____-_____

Guardian

Last name: _____

First name: _____Middle name, suffix_____

RESPONSIBLE PARTY INFORMATION *(Guarantor) Person to be billed, if other than the patient*

RELATIONSHIP TO PATIENT [ ] Self (skip to next section) [ ] Spouse [ ] Parent [ ] Other

Last Name:_____ First Name:_____

SSN#:_____-_____-_____ Date of Birth: ___/___/____ Gender: [ ]Male [ ]Female

Address (if different from above):_____

City:_____ State: _____Zip Code:_____

Home Phone:( )_____-_____ Cell Phone:( )_____-_____ Work Phone:( )____-_____

Employer:_____ Address_____

City:_____ State:_____ Zip_____

Patient Name:_____Date of Birth:_____

**MEDICAL * INSURANCE INFORMATION

[ ] No Insurance [ ]Medicaid/Illinois/MCO [ ]Medicare [ ]Other (Private/Commercial) [ ] Slide Fee Program

❖ PRIMARY INSURANCE

Patient's Relationship to Policy Holder: [ ] Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____-_____-_____ Policy Holders Date of Birth:_____

Effective Date (*if known*):_____ Co-pay Amount $_____

Employer:_____ Phone: ( )_____-_____

Employer Address_____ City:_____ State:___Zip:_____

❖ SECONDARY INSURANCE

[ ] None-skip to next section [ ]Medicaid/Illinois/MCO [ ]Medicare [ ]Other (Private/Commercial)

Patient's Relationship to Policy Holder: [ ] Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____ -_____-_____ Policy Holders Date of Birth:_____

Employer:_____ Phone: ( )_____-_____

**DENTAL * INSURANCE INFORMATION

[ ] No Insurance [ ]Medicaid/Illinois/MCO [ ]Medicare [ ]Other (Private/Commercial) [ ] Slide Fee Program

❖ PRIMARY INSURANCE

- **Patient's Relationship to Policy Holder**: [ ]Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____-_____-_____ Policy Holders Date of Birth:_____

Effective Date (*if known*):_____ Co-pay Amount $_____

Employer:_____ Phone: ( )_____-_____

Employer Address_____ City:_____ State:___Zip:_____

❖ SECONDARY INSURANCE

[ ] None-skip to next section [ ]Medicaid/Illinois/MCO [ ] Medicare [ ] Other (Private/Commercial)

- **Patient's Relationship to Policy Holder**: [ ]Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____-_____-_____ Policy Holders Date of Birth:_____

Employer:_____ Phone: ( )_____-_____