RURAL HEALTH, Inc.
We specialize in you

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

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

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: _____

Patient Home Address: _____

Mailing Address: _____

City_____State_____Zip_____

Email: _____@_____

Access to Patient Portal: [ ] Yes [ ] No

Patient Phone: Cell ( ) _____-_____

- Consent to call - cell [ ] Yes [ ] No Consent to text [ ] Yes [ ] No

Home Phone ( )_____-_____ Work Phone ( ) _____- _____

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

Pharmacy: _____ Address: _____City _____State_____

Pharmacy Phone:( )_____-_____

Driver's License Number: _____State _____Expiration Date_____

Patient Name: _____Date of Birth_____
****

*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

Race [ ] African American [ ]American Indian [ ] American Indian or Alaska Native [ ]Asian [ ]Black [ ]Black or African American [ ]Native Hawaiian [ ] Other Race [ ] White [ ] Decline to Disclose

Ethnicity [ ] Central American [ ] Cuban [ ] Dominican [ ]Hispanic or Latino [ ] Mexican [ ]Not Hispanic or Latino [ ] Puerto Rican [ ] South American [ ] Spaniard [ ] Declined to Disclose

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

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: ( )_____-_____