VIP COMMUNITY SERVICES

# REGISTRATION FORM

## PATIENT INFORMATION

Legal last name: | Legal First: | Middle: | Today's date: / /

Chosen first name (if different): | Date of Birth: / / | Social Security number: - -

Billing Address: | Apartment #: | Cell phone number: ( ) | Which is your primary contact number? ☐ Cell ☐ Home ☐ Work

City: | State: | Home phone number: ( )

E-Mail Address for Patient Portal:
*** Must be 18 years of age or older***

Work phone number: ( )

**Preferred Pronoun:**

☐ He ☐ She ☐ They ☐ Ze ☐ A pronoun not listed ☐ No pronoun preference

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these question were provided by our funders. Please help us serve you better by selecting the best answers to these questions. Thank You.

**Preferred Spoken/Written Language:**
☐ English ☐ Spanish
☐ French ☐ Other

Language interpretation services needed?
☐ No
☐ Yes, language: _____

**Race:** * Select all that apply*
☐ Black and/or African American ☐ White/Caucasian
☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ More than one race
☐ Decline to Answer

**Veteran?** ☐ Yes ☐ No

**Migrant Worker?**
☐ Yes ☐ No

**Sexual Orientation**
☐ Lesbian
☐ Gay ☐ Straight
☐ Bisexual ☐ Something Else
☐ Don't Know ☐ Decline to Answer

**Recent Hospitalization?**
☐ Yes, date: _____
☐ No

**Ethnicity:**
☐ Non-Hispanic/Latino
☐ Other Hispanic/Latino
☐ Decline Answer

**How did you first learn of VIP?**
☐ Friend/Patient
☐ Referral
☐ Health Fair/Presentation
☐ VIP Website/Internet
☐ Facebook/Social Media
☐ TV/Radio/Print Media

**Gender Identity:**
☐ Man ☐ Woman
☐ Trans Man ☐ Trans Woman
☐ Other: _____
☐ Decline to Answer

**Highest Level of Education?**
☐ Grade School
☐ High School/GED
☐ College ☐ Graduate School

**Do you have a lease in your name?**
☐ Yes ☐ No
If "No", select which best applies:
☐ Living on the street
☐ Homeless Shelter
☐ Transitional
☐ Doubling Up (not paying rent)
☐ Other

**Do you have a current primary care provider that you want to continue to see?**
☐ Yes ☐ No

If yes, will you sign a release of information?
☐ Yes ☐ No

**Sex Assigned at Birth:**
☐ Male ☐ Intersex
☐ Female ☐ Decline to Answer

**Employment Status:**
☐ Full-time/Part-time
☐ Retired ☐ Unemployed
☐ Disabled/Unable to work

## Emergency Contact

Emergency contact name: | Relation to patient:

Emergency contact phone: ( )

VIP COMMUNITY SERVICES

# REGISTRATION FORM

## CONSENT FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ (Please Print)  Date of Birth: _____ (MM/DD/YY)

I hereby authorize the physicians, physician assistants, nurse practitioners and mental health staff of VIP to conduct routine examinations, to obtain specimens, including blood, to perform such tests, and administer treatments, including the injections of pharmaceutical products (medications) and immunizations to myself as may be deemed necessary now and on subsequent days.

I have been informed about the patient's bill of rights and responsibilities.

☐ I do not have an advance directive

☐ I have an executed advance directive

TYPE: ☐ Health Care Proxy ☐ Living Will ☐ Other _____

We accept most insurance plans; however, you are responsible for verifying that we are a participating member with your insurance. If you do not have insurance, we are still committed to serving you. We offer a sliding fee scale (based on income) for payment. We also have dedicated staff members available to help patients enroll in insurance plans.

| **INSURANCE INFORMATION** | Do you have health insurance? ☐ Yes ☐ No | |
|---|---|---|
| Insurance is through employer ☐ Yes ☐ No | Are you the responsible party? ☐ Yes ☐ No | |
| Insurance carrier: | Policy #: | Group #: |
| Name of insurance (if different): | Address of Insured: | |
| Sex listed on insured's health insurance plan: ☐ Male ☐ Female | Insured's birth date: / / ☐ All information same as patient | |

I hereby authorize VIP to furnish medical information to my insurance carrier in accordance with their privacy policy.

By signing this acknowledgement, you (or the guarantor for the patient) accept full responsibility for payment of the services and supplies rendered by VIP.

Name of Patient
Or Responsible Party: _____ (Print)  Date: _____

Signature of Patient
Or Responsible Party: _____  Date: _____

Witnessed (VIP Staff): _____ (Print)  Date: _____

VIP COMMUNITY SERVICES

# REGISTRATION FORM

| ANNUAL HOUSEHOLD INCOME | | | | |
|---|---|---|---|---|
| Source | Self | Spouse | Other | Total |
| Gross wages, salaries, tips, etc. | | | | |
| Income from business, self-employment, and dependents | | | | |
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security income, public assistance, veteran's payments, survivor benefits, pension or retirement income | | | | |
| Interest, dividends, rents<br>Educational assistance, alimony, child support, assistance from outside the household, and other income sources | | | | |
| **Total Income** | | | | |

**NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.**

**I certify that the family size and income information shown above is correct.**

Name (Print) _____

Signature _____ Date _____

**Office Use Only**

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

| Verification Checklist | Yes | No |
|---|---|---|
| Identification/Address: Driver's license, utility bill, employment ID, or other | | |
| Income: Prior year tax return, three most recent pay stubs, or other | | |
| Insurance: Insurance Cards | | |