Valley Community Healthcare

Patient Label: ____________________

RA1

REGISTRATION FORM

Preferred Name: *(last name, first name, middle initial)*	**Social Security #:**	**Birth Date:**
Legal Name: *(if different than above)*	**Sex:** ☐ M ☐ F *(ID, birth certificate)*	○ MTF ○ FTM *(mark if applicable)*
Street Address:	**Mother's Maiden Name:** *(first and last)*	

City:	**State:**	**Zip code:**

Preferred Language: ☐English ☐Spanish ☐Arabic ☐Armenian ☐Farsi ☐French ☐Korean ☐Russian ☐Other

If we get your answering machine/voicemail, what do you prefer? ☐DO NOT leave a message, try later. ☐OK to leave a message, caller is permitted to identify VCH. ☐DO NOT leave a message. Call my confidential contact and ask them to tell me to call VCH. *(enter contact information below Emergency Contacts)*	**Primary Phone #:** **Cell Phone #:** **Confidential Cell #:** *(text reminders only)*

Email:____

Marital Status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Widowed | **Are you a veteran?** ☐ Yes ☐ No

Student Status: ☐ Not a Student ☐ Full Time ☐ Part Time | **Current School:** ________________ ☐ N/A

What is your current housing situation? *(mark one)* ☐ Own ☐ Rent ☐ With Family/Friends ☐ Shelter ☐ Homeless ☐ Other | **Are you a migrant or seasonal farm worker?** ☐ Yes ☐ No

Do you need an interpreter? ☐ Yes ☐ No | **Do you use a TTY?** *(text telephone)* ☐ Yes ☐ No

What is your race? *Check one or more:* ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Asian ☐ Filipino ☐ Other Pacific Islander ☐ White ☐ Decline to state

Do you consider yourself Hispanic or Latina/o? ☐ Yes ☐ No

Emergency Contact 1: Name:	Phone #:	Relationship:
Emergency Contact 2: Name:	Phone #:	Relationship:
Confidential Contact: Name:	Phone #:	Relationship:

Are you employed? ☐ Yes ☐ No | **If yes, what is your job?** ______________________________

Do you have a primary caregiver? ☐Yes ☐No

If yes: Name: *(first & last)*____________________Relationship: ________________ Phone #: __________

Preferred Contact Method: ☐ Primary Phone ☐ Cell Phone ☐ Text ☐ Letter ☐ Email

Do you want text appointment reminders? ☐ No. ☐ Yes, use cell #. ☐ Yes, use confidential cell. *(write above)*

Do you have any contact restrictions? ☐No restrictions ☐No texts ☐No calls ☐No letters ☐No emails

Do you have an Advance Directive? ☐ Yes ☐ No
(If yes, please provide a copy for our records at your next appointment)

Would you like information regarding Advance Directives? ☐ Yes ☐ No

Primary Care Only - GUARANTOR			
Name:		**Social Security #:**	**Date of Birth:**
Relationship:	**Address:**		**Phone #:**
Income: **$**	**☐ Annually ☐ Monthly ☐ Weekly ☐ 2 Weeks ☐ Other**		**Number In Family:**

Insurance Information

Do you currently have any type of health care coverage?

☐ No Coverage

☐ Medi-Cal: ☐ Fee for Service ☐ Emergency Only ☐ Share of cost Amount of share of cost: $.

☐ Medicare: ☐ Part A only ☐ Part B only ☐ Part A & B ☐ Part A, B & D

☐ Managed Care (HMO): Health Plan Name: .

☐ Private Insurance

☐ My Health LA

☐ Other: .

How did you discover Valley Community Healthcare?

(for example, referred by a patient, saw an ad/billboard)

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Valley Community Healthcare is dedicated to providing our patients with the highest quality health care, regardless of coverage. In order to do so, it is important that you provide us with accurate and true information. We use this information in order to identify you and determine your eligibility in order to complete claims for various health care programs. This information is also used to determine if these programs cover the services and supplies you receive.

Many insurance companies, including Medicare, require a co-payment and/or deductible payment from the patient. You are responsible for these payments and will be billed. In addition, failure to provide Valley Community Healthcare with accurate and true information may result in denial for payment of your services, in which case you will be financially responsible for all charges.

I certify and declare under penalty of perjury, under the laws of the State of California, that I understand this form and that the information provided is true, correct and complete.

Patient signature: ____ Date: ________________

Responsible relative signature:______________________________ Relationship: ________________

Please do not write below this point.

Registered by: ________________________ **Date:** __________

Encounter Label