Isabella Citizens for Health Registration: **PLEASE PRINT CLEARLY**

Today's Date:

PATIENT INFORMATION

Last name: **First:** **Middle:**

Marital status: ☐Single ☐ Married ☐ Divorced ☐Widowed ☐Legally Separated

E-MAIL ADDRESS:
☐ Check this box if you do not have an e-mail address.

Preferred Method of Contact: ☐Text ☐E-mail ☐Phone

As a Federally Qualified Health Center, we are required by the Federal Government to ask more questions than a typical demographic form. We ask about income because our low-income patients may qualify for discounted services. If you have any questions, please feel free to ask.

Primary Phone:	**Secondary Phone:**	**Work Phone:**	**Birth date:**	**SS #**

Address: **City:** **State:** **Zip Code:** **PO Box:** **Apt./Lot #:**

Secondary Address: **City:** **State:** **Zip Code:** **PO Box:** **Apt./Lot #:**

Preferred Language:
☐ English
☐ Spanish
☐ Other (Please Specify): _____

Race:
☐ White/Caucasian ☐ African American/Black
☐ American Indian/Alaskan Native ☐ Multi-Racial
☐ Asian ☐ Other Pacific Islander
☐ Native Hawaiian ☐ Unknown/Refuse to Report

Ethnicity:
☐ Non-Hispanic/Latino
☐ Hispanic/Latino
☐ Decline To Answer

Sex:
☐ Male
☐ Female

Employment Status:
☐Full Time ☐Part Time ☐Not Employed

Employer:

Student Status:
☐ N/A ☐Full Time ☐ Part Time

Household Income:_____ ☐ Decline To Report
Please specify (circle): Weekly/Monthly/Annually
Household Size: _____

Do you live in public housing? ☐Yes ☐ No
Were you homeless within the last 12 months? ☐Yes ☐No
Are you a Veteran? ☐Yes ☐No
Are you a migrant or seasonal agricultural worker? ☐ Yes ☐No

GUARANTOR INFORMATION

Guarantor (if not patient):	Relationship to patient:	Birth date:	Social Security #:
Address:	Phone:	Employer:	

PRIMARY INSURANCE INFORMATION **(Please be sure to present copy of card(s) to receptionist)**

Name of primary insurance:	Subscriber's name:	Birth date:	Policy Number:	Group Number:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Birth date:	Policy Number:	Group Number:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone Number:	Alt Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Isabella Citizens for Health or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date