TULIP TREE
FAMILY HEALTH CARE

PATIENT REGISTRATION FORM

PATIENT INFORMATION — PLEASE FILL OUT ENTIRE FORM IN BLUE OR BLACK INK ONLY

LAST NAME FIRST NAME MIDDLE INITIAL

MAILING ADDRESS CITY STATE ZIP

PRIMARY PHONE SECONDARY PHONE WORK PHONE EMAIL ADDRESS FOR PATIENT PORTAL ACCESS

PREFERRED CONTACT METHOD PRIMARY PHONE____ SECONDARY PHONE____ WORK PHONE____ CALL_____ TEXT_____

DATE OF BIRTH SEX AT BIRTH M___ F ___ SOCIAL SECURITY NUMBER

GENDER MALE _____ FEMALE _____ TRANSGENDER MALE _____ TRANSGENDER FEMALE _____ OTHER _____ DO NOT WISH TO REPORT _____

SEXUAL ORIENTATION BISEXUAL____ LESBIAN OR GAY ____ STRAIGHT/HETEROSEXUAL ____ SOMETHING ELSE____ DON'T KNOW____ DO NOT WISH TO REPORT _____

RESPONSIBLE PARTY INFORMATION — *ANY PARTY UNDER 18 MUST HAVE A RESPONSIBLE PARTY*

PATIENT ☐ 18 OR OLDER CUSTODIAL PARENT ☐ GUARDIAN ☐ PROOF OF LEAGAL STATUS REQUIRED FOR TREATMENT

LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS CITY STATE ZIP

DATE OF BIRTH HOME PHONE

PATIENT EMERGENCY CONTACT NAME RELATIONSHIP TO PATIENT AND PHONE NUMBER

MEDICAL INSURANCE

I CURRENTLY **HAVE MEDICAL INSURANCE** SEE BELOW ☐ I CURRENTLY **DO NOT HAVE MEDICAL INSURANCE** ☐

I WOULD LIKE TO APPLY FOR THE SLIDING FEE SCALE DISCOUNT ☐

PRIMARY INSURANCE NAME_____ SECONDARY INSURANCE NAME _____

POLICY NUMBER _____ POLICY NUMBER _____

GROUP NUMBER _____ GROUP NUMBER_____

POLICY HOLDER NAME_____ DATE OF BIRTH_____ POLICY HOLDER NAME_____DATE OF BIRTH_____

RACE CHECK ALL THAT APPLY AFRICAN AMERICAN_____ ASIAN _____ NATIVE AMERICAN/ALASKA NATIVE_____ NATIVE HAWAIIAN _____

OTHER/ PACIFIC ISLAND _____ WHITE _____ **ETHNICITY** NON HISPANIC_____ HISPANIC_____

IF WE HAVE NOT UPDATED YOUR PATIENT PHOTO WITHIN THE LAST 24 MONTHS, PLEASE LET US KNOW SO WE CAN KEEP YOUR FILE CURRENT

PHARMACY NAME AND TOWN _____ PRIMARY CARE PROVIDER _____

FAMILY FINANCIAL INFORMATION

FAMILY/HOUSEHOLD SIZE _____ HOUSEHOLD INCOME _____ WEEKLY BI WEEKLY MONTHLY ANNUALLY

ARE YOU HOMELESS Y___ N___ **ARE YOU A VETERAN** Y___ N___ **AGRICULTURAL WORKER** SEASONAL___ MIGRANT___

PRIMARY LANGUAGE IF NOT ENGLISH _____ **REQUEST TRANSLATION SERVICES** _____

I HAVE READ THE NOTICE OF PRIVACY PRACTICES FOR TULIP TREE HEALTHCARE _____
I HAVE DECLINED TO READ THE NOTICE OF PRIVACY PRACTICES, BUT I AM AWARE THERE IS A COPY POSTED IN THE OFFICE _____

SIGNATURE OF PATIENT OR GUARDIAN_____ **PRINTED NAME**_____ **DATE**_____

HOW DID YOU HEAR ABOUT US? CURRENT PATIENT_____ LIVE NEARBY/LOCALLY _____ FAMILY /FRIEND _____ NEWSPAPER/ONLINE _____

OTHER (PLEASE SPECIFY) _____

TULIP TREE
FAMILY HEALTH CARE

Release of Information and Financial Responsibility

On behalf of myself or my dependent, I authorize Tulip Tree Health Services of Gibson County, Inc. to release information regarding medical treatments for insurance and assign all insurance payments for services rendered to Tulip Tree Health Services. I authorize the use of this signature, and any copy, on all insurance submissions.

I understand that I am responsible for fees at the time services are rendered. I understand that I am responsible for any portion of fees not paid by my benefits or discounts, and if I cannot pay in full, I agree to make payment arrangements.

Signature: _____ Date: _____

Medication History Consent:

Pursuant to new regulations, Tulip Tree Family Health Care utilizes electronic prescribing, (ePrescribing). ePrescribing allows for the most accurate and direct method of exchanging prescription information with pharmacies and is designed and regulated to improve patient care. By signing this consent form, you are agreeing that Tulip Tree Family Health Care can request your prescription medication history from pharmacies, other healthcare providers and health care payers to assist in treatment at Tulip Tree Family Health Care.

Signature: _____ Date: _____