COPLIN HEALTH SYSTEMS

Patient Name: _____ Date of Birth: _____

Registration Form

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unknown Social Security Number: _____

Name: _____ Preferred Name: _____

Street Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Communication Preference: (*for appointment reminders etc.*) ☐ Voice ☐ Text ☐ Email

Email: _____ ☐ Does not have email ☐ Will not disclose ☐ Other

Employer/School: _____ Phone: _____

Preferred Provider: _____ Primary Care Provider: _____

I was referred to Coplin Health Systems by (Individual or Doctor): _____

Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Translator needed

Responsible Party: (Responsible for Bill) ☐ Same as above

If different from patient (*please complete below*)

Name: _____ Birthdate: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Relationship to Patient: _____

Parent/Guardian Information (court issued guardian/custody documentation is required)

Father: _____ Date of birth: _____ (email) _____

Phone (H)_____ (W)_____ (C) _____

Mother: _____ Date of birth: _____ (email) _____

Phone (H)_____ (W)_____ (C) _____

Guardian: _____ Date of birth: _____ (email) _____

Phone (H)_____ (W)_____ (C) _____

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact if I cannot be reached, medical information regarding the above-named patient will be shared between the medical provider and the alternative contact (including all relevant information with exception to psychiatric/mental health, alcohol/drugs, and HIV / AIDS information).

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____

May we leave a message? __ Y __N

Phone: (Home) _____ Work) _____ (Cell) _____

I, _____, Authorize Coplin Health Systems to share my personal health information with the named persons below. (Please **circle** which information Coplin Health Systems is authorized to share with each named person)

Name: _____ Date of Birth _____ Relationship to Patient: _____

Phone: _____ Medical Dental Billing Scheduling Behavioral Health SUDS HIV/AIDS ALL

Name: _____ Date of Birth _____ Relationship to Patient: _____

Phone: _____ Medical Dental Billing Scheduling Behavioral Health SUDS HIV/AIDS ALL

Name: _____ Date of Birth _____ Relationship to Patient: _____

Phone: _____ Medical Dental Billing Scheduling Behavioral Health SUDS HIV/AIDS ALL

COPLIN HEALTH SYSTEMS

Patient Name: _____ Date of Birth: _____

Insurance Information-Please write any additional information the back of form.

☐ **Primary Health Insurance:** Name of Insured Parent / Guardian_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

☐ **Secondary Health Insurance**: Name of Insured Parent / Guardian_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

☐ **Dental Insurance**: Name of Insured Parent/Guardian:_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

☐ **Secondary Dental Insurance**: Name of Insured Parent/Guardian:_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

Health Information *(Additional health, family & developmental history will be collected visit.)*
Preferred Pharmacy Name: _____
Address_____ Phone Number: _____
Secondary Pharmacy Name: _____
Address_____ Phone Number: _____

☐ **No health insurance**
☐ **Request application for sliding fee**
☐ **I want assistance from Coplin Health Systems to obtain insurance**

COPLIN HEALTH SYSTEMS

Patient Name: _____ Date of Birth: _____

Current Medications

Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:

Social Demographic Survey

Coplin Health Systems is a Federally Qualified Health Center (FQHC), as such we qualify for special pricing and discounted costs for our patients. To ensure that we continue to receive this designation and funding, we must report specific information about the population that we serve.
We ask that you assist us by completing the following information.

How many people are currently living in your household? (Circle the correct answer) 1 2 3 4 5 6 7 8 9

What is your estimated household monthly net income?

$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000
$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000

Household Status: ☐ Own my home ☐ Rent ☐ Live with someone ☐ In Shelter ☐ Transitional ☐ Homeless
Military Status: ☐ Not a Veteran ☐ Veteran ☐ Active Service
Disability Status: Do you have a disability as identified by the Americans with Disabilities Act? ☐ Yes ☐ No
Gender: ☐Female ☐ Male ☐Transgender Male ☐Transgender Female ☐Choose not to disclose
Sexual Orientation: ☐Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Do not know ☐Choose not to disclose
Race: ☐White ☐ Black ☐ American Indian/Alaskan Native☐ Native Hawaiian ☐ Pacific Islander ☐ Asian ☐Native American or Other if so list: _____
Ethnicity: ☐Decline to Specify ☐ Not Hispanic/Latino ☐ Hispanic/Latino
Marital Status: ☐ Married ☐ Single ☐Divorced ☐Partner ☐ Widowed ☐Legally separated ☐Unknown
Employment Status: ☐ Employed ☐ Not employed ☐Self-employed ☐ Retired ☐ On active military duty ☐Reserved for national assignment☐ Unknown
Student Status: ☐ Full-time Student ☐ Not a student ☐Part-time student

COPLIN HEALTH SYSTEMS

Patient Name: _____ Date of Birth: _____

Consents

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed and how a patient may obtain access to their personal health information. This notice can be found on our website at www.coplinhealth.com or by requesting a copy from Coplin Health Systems' staff. Your signature of this form certifies that you have reviewed the Notice of Privacy Practices. The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Coplin Health Systems' care operational and other purposes that are permitted and required by law. It also describes my rights to access and control my protected health care information. The Notice of Privacy Practices is also posted in the waiting areas.

I have read and understand the registration form. I understand the HIPAA acknowledgment and know how to obtain a copy of the Notice of Privacy Practices. I understand and agree to the Financial Policy. I have accurately and truthfully completed this form to the best of my ability. I understand and agree to the consents as I have marked above. I understand that by providing my contact information, Coplin Health Systems may use those methods to contact me. I understand and agree that I cannot share my patient portal login information with others, to ensure my privacy. I understand and agree for my information will be shared with the WV and OH Health Information Networks; if I want to remove this access, I understand that I will need to provide a written statement to opt out. I understand I am consenting to medical treatment for myself and/or the patient I am responsible for, as listed above. I understand that I am financially responsible for any balance. I also authorize Coplin Health Systems or my insurance company to release any information required to process my claims.

- I agree to allow Coplin Health Systems access to my prescription history: ☐ Yes ☐ No
- I agree to leave my credit/debit card on file: ☐ Yes ☐ No
- I agree to have nursing and/or medical students present during my care: ☐ Yes ☐ No
- I agree to allow Coplin Health Systems to send and receive applicant's health information through CommonWell and CareQuality with other medical facilities for continuity of care (information sheets can be provided): ☐ Yes ☐ No
  Including (facilities/offices applicant receive medical care): _____

_____ _____

Printed Name of Patient or Responsible Party **Printed Patient Name (if Different than Responsible Party)**

_____ _____

Signature of Patient or Responsible Party **Date**