Ilanka Community Health Center
PATIENT REGISTRATION FORM

May magagamit na mga serbisyo sa pagsasalin.
Kung kailangan mo ng tulong sa pagbabasa o pag kumpleto ng mga documentong ito maaring markahan ang kahon. ☐

Sercicios de traducción disponibles.
Si necesita ayuda para leer o cmpletar este formulario, marque la casilla. ☐

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Previous Last Name: _____ Preferred Name: _____

SSN: _____ Date of Birth: _____ Gender: □ Male □ Female

If minor patient, Name of Guarantor / Responsible Party: _____

MAILING ADDRESS _____

PHYSICAL ADDRESS _____

City: _____

State: _____ Zip: _____

Preferred Contact Phone #: _____

Email Address: _____

PERMANENT ADDRESS _____

City: _____

State: _____ Zip: _____

Permanent Home Phone #: _____

Mobile Phone #: _____

Please select a Primary Care Provider:

Dr. Benjamin Head: ◯ Dr. Brian Iutzi: ◯

Dr. Laily Mahoozi: ◯

Bios available, please request at Front Desk

PATIENT EMPLOYER: □ Minor patient □ Unemployed

□ Disabled □ Retired Retirement Date: _____

Name of Employer (If employed): _____

Employer Phone #: _____ □ Full-time □ Part-time

MARITAL STATUS: □ Divorced □ Life Partner □ Married □ Separated □ Single □ Unknown □ Widowed

DEMOGRAPHIC INFORMATION

Our federal grant requires us to collect and report on this information, in an effort to provide culturally competent healthcare services. The information is reported on the population as a whole, not by specific individual.

Race (***select all that apply***):
- □ Alaska Native / American Indian Tribe:_____
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian
- □ Native Hawaiian
- □ Other Pacific Islander
- □ Guamanian or Chamorro
- □ Samoan
- □ Black / African American
- □ White
- □ Other
- □ Unknown
- □ Choose Not to Disclose

Ethnicity (***select all that apply***):
- □ Mexican
- □ Mexican American
- □ Chicano/a
- □ Puerto Rican
- □ Cuban
- □ Another Spanish culture or origin
- □ Not Hispanic/Latino or Spanish Origin
- □ Unknown
- □ Choose not to disclose

Total number in your household: _____

Annual Household income: _____

Would you like to apply for sliding fee discounts? □ Yes □ No

**Our federal grant requires us to collect and report on household income information for all patients regularly (not only patients applying for a sliding fee discount).*

Preferred Language:
- □ English
- □ Other (please identify) _____

Interpreter Required?
- □ Yes
- □ No

Veteran Status:
(Have you ever served in the U.S. Military?)
- □ Yes
- □ No

Are you homeless?
□ Yes □ No

Are you a migrant or seasonal worker?
□ Yes □ No

BILLING INFORMATION

Guarantor / Responsible Party □ patient / same as above

Last Name: _____ First Name: _____ Middle: _____

SSN: _____ Date of Birth: _____ Gender: □ Male □ Female

MAILING ADDRESS _____ Home Phone: _____

PHYSICAL ADDRESS _____ Other Phone: _____

City: _____ State: _____ Zip: _____

EMPLOYER: (□ no employer) _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____Policy # _____Group #: _____

Policy Holder Name: _____Date of Birth: _____SSN: _____ Gender: _____

Relationship to Patient: _____Employer: _____ Work Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Policy # _____ Group #: _____

Policy Holder Name: _____

Date of Birth: _____SSN: _____ Gender: _____

Relationship to Patient: _____

Employer: _____ Work Phone: _____

TERTIARY INUSURANCE INFORMATION:

Insurance Company: _____

Policy # _____ Group #: _____

Policy Holder Name: _____

Date of Birth: _____ SSN: _____ Gender: _____

Relationship to Patient: _____

Employer: _____ Work Phone: _____

EMERGENCY CONTACT:

Name: _____

Date of Birth: _____

Phone: _____

Relationship to Patient: _____

NEXT OF KIN:

Name: _____

Date of Birth: _____

Phone: _____

Relationship to Patient: _____

CONSENT FOR EVALUATION AND TREATMENT:

Ilanka Community Health Center provides comprehensive Primary Care and Behavioral Health services. Since wellness involves body and mind, our providers may involve other healthcare specialists such as Behavioral Health Clinicians, a Care Coordinator or telehealth providers as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure continuity of care. *If you prefer to limit the sharing of information, please inform the Front Desk Staff before your appointment.*

By signing this form, I agree that I have read or had this form read and/or explained to me, that I understand it and that my questions have been answered. I agree to provide accurate information.

Thus, I hereby consent for Ilanka Community Health Center to evaluate and administer treatment for myself and/or child(ren) as set forth above, including any procedures that ICHC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally authorized to make such decisions.

Patient Name:_____ Patient DOB: :_____

Signature:_____ Date:_____

Printed Name if Parent/Guardian Signing:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review the Notice.

Printed Name: _____ (□ minor) Signature: _____

Date: _____ Relationship to minor patient: _____

INFORMATION FORM - ADDITIONAL FEES

Please note that your plan of care/treatment from your visits at Ilanka Community Health Center may include equipment, supplies or services.

Examples include, but are not limited to, medications, orthopedic supplies such as braces or slings and possibly lab work or ultrasounds. These have additional fees associated with them. Please feel free to ask your provider for pricing.

SLIDING FEE DISCOUNT PATIENTS:

Sliding fee discounts for services provided by Eye Guys or Prism Optical only applies to eye exams. Should you choose to have a contact lens exam or purchase hardware, such as eyeglasses or contact lens, it will result in additional out-of-pocket costs which are not covered under Ilanka's Sliding Fee Discount Program.

If you were referred to Dr. Urata, DMD for teeth cleaning services, any additional services that are chosen or recommended during your visit will result in additional out-of-pocket costs and are not covered under the Sliding Fee Discount Program.

_____

Patient Signature Date

_____

Printed Name

If you have any questions or concerns, please contact:
Shannon Mallory, Revenue Cycle Manager at 424-3622