

Health Record #	
(For office use only)	

Hunter Health Patient Registration Form

PATIENT INFORMATION					
*Legal Name:					
Last First Middle Preferred Name *Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name is different from these, please let us know.					
Birth Date: Street Address:			Are you a Veteran: Yes No Po Box: Service Branch:		
City	State	Zip Code	Home Phone:	Cell Phone:	
Occupation: Employer: Full Time Part Time		Employer:		Work Phone:	
	De	mographic Infor	mation:		
Marital Status: Single	Married	Divorced [Separated Widowe	d	
Preferred Language: English Spanish Vietnamese Do you need a translator: Other: Do you need a translator: Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown					
Zamiety. — Net rispanie of Zatine — Inspanie of Zatine — on the same					
Race: American Indian/ Alaska Native Asian Black or African American Tribe: Slipino Native Hawaiian or Pacific Islander White Other					
Assigned Sex at Birth:					
☐ Male ☐ Female ☐ Choose Not to Disclose			*Sexual Orientation: (Not required if under the age of 18.)		
* I currently identify as:					
☐ Male ☐ Female		Straight (Not Lesbian or gay)			
Transgender Male (Female to Male)		Lesbian or Gay Bisexual			
Transgender Female (Male to Female)		Something Else	Don't Know		
Choose Not to Disclose	Other		Choose Not to Disclose		

^{*}Sexual orientation and gender identity can play a significant role in determining health outcomes. Please see the front desk or ask your healthcare team if you have questions about disclosing this information.



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Internet Access: Yes	No Where: (Home, Mobile, Etc)			Email Addres	ss:
Do we have permission to send generic health information to your email address?					
Preferred Method of Commur	nication: Em	nail 🗌 Lette	er Ph	one Do Not N	otify
	IF I	PATIENT IS UN	DER AGE	18:	
Legal Guardian: Relationship to Patient:					
Father's Name:	Fathe	r's Employer:		Phone:	
Mother's Name:	Mother's Employer:			Phone:	
		INCOME INFO	RMATION	 	
Number in Household: Total Household Income: Week		ome:	Per Year/ Month/ Bi-Weekly/		
				(Ci	rcle One)
	IN	ISURANCE INF	ORMATIC	N	
Type of Insurance:	are Medi	caid 🗌 Pri	vate Insura	ance None	
Insurance Company:			ID #:		
Subscriber Name: Subscriber Date of		oer Date of	f Birth: Sex: M F		
		IN CASE OF EM	1ERGENC\	1	<u>.</u>
Emergency Contact Name: Last First Middle			Middle		
Street Address:			Relationship:		
City	State	Zip Code		Home Phone:	Cell Phone:
		Next of	Kin		
Name: Last	Firs		<u></u>	Middle	
Street Address:				Relationship:	
City	State	Zip Code		Home Phone:	Cell Phone:
Please bring the following to you Photo ID Proof of Income Insurance Card (if applicable Tribal Identification/Verificatio	e)				

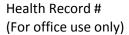
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Hunter Health

PERMISSION TO DISCLOSE CONFIDENTIAL INFORMATION & Acknowledgement Of Receipt of Notice of Privacy Practices

	(Name)		(DOB)	
				for the following purposes
	(Address)	(Pho	ne)	
>				coordinating or managing care between physicians and other healt
>	Health Care Operation health care provider.)	s- (Includes the necessa	ry administrative	e and business functions of your
>	•	iends, etc. who you wo ONE	uld like to have	access to your protected health
		of Privacy Practices" fo cribed in the CONSENT p		rmation about the uses and he CONSENT.
	ning below, you verify t cy Practices.	hat you have received a	copy of, or been	offered, Hunter Health's Notice of
	•	e this CONSENT, in wri ly used or disclosed in	•	
Signat	ture of Patient/ Patient	Representative	Date	
 Relati	onship to Patient			





Authorization

Hunter Health is dedicated to providing comprehensive primary care, dental, and behavioral health services. Because wellness involves both the body and mind, our team of providers work together to offer you high quality whole person healthcare. Your providers may involve other healthcare specialists as

Signature of Patient/ Patient Representative	Relationship to Patient	 Date
Signature		
I acknowledge that I am responsible for all charges for se covered by my Health Insurance Plan or for which I am re extent no coverage exists, I acknowledge that I am respor charges. I further agree that, if permissible by law, I will refees that may be incurred by Hunter Health to collect those	esponsible for payment under my Heal nsible for all charges for services provides eimburse Hunter Health for all costs, e	th Insurance Plan. To the ded and agree to pay all
Patient Responsibility		
I request that payment of authorized benefits be made on patient listed above by Hunter Health physicians and hea payments to Hunter Health. I authorize Hunter Health to adverse benefit determination related to services and car to Hunter Health, I agree to forward to Hunter Health all I rendered by Hunter Health and its health care providers.	lth care providers, and I assign my righ file an appeal on my behalf for any den re provided. If my Health Insurance Pla health insurance payments, which I red	nt to receive these hial of payment and/or n will not direct paymen
Assignment of Benefits		
Thus, I, hereby ask for myself and/or child(ren) as set forth above, includinterventions and/or procedures that Hunter Heappropriate. If signing as parent or guardian, I herempowered and entitled to make such decisions.	lth professional staff decide are no	eatment ecessary or
I understand that if I am 16 years of age or older, I including mental health services; if I am 18 years of services; otherwise my parent or legal guardian w (parent or legal guardian signature, if required) I a explained to me, that I understand it and that any that I agree to be truthful in providing information	of age or older, I may consent for a fill need to consent to services. By agree that I have read or had this f questions I asked have been answ	all other health signing this form, Form read and/or
you high quality whole person healthcare. Your pr part of your care team. Members of your health ca as needed to ensure enhanced continuity of care.		-