CommunityHealth

NEW PATIENT REGISTRATION FORM

Patient Information

Legal Last name_____

Legal First name_____ Middle Initial _____

Preferred Name _____

Legal Sex (please check one) ☐Male ☐Female

Date of birth_____/_____/_____

Address_____ Apt #_____

City_____ State_____ Zip code_____

☐I'm currently homeless

Cell phone # (_____)_____ ☐Preferred ☐Consent to text

Home phone # (_____)_____ ☐Preferred

Email _____

Emergency Contact

Name _____ Relationship _____

Phone # (_____)_____ Alternate phone # (_____)_____

☐This is my legal guardian

Insurance Information

What type of health insurance do you have?

☐Medicaid ☐Medicare ☐Private insurance/work benefits ☐Student health insurance
☐Veterans benefits ☐I do not have any health insurance

Medicaid - You may be eligible for Medicaid if any of the below options apply to you:

1. If you are a U.S. citizen or resident with 5 or more years of residency and your yearly income is at or below 138% of the Federal Poverty Level.

2. You are not a U.S. citizen or resident, but are aged 65 or older, and your yearly income is at or below 100% of the Federal Poverty Level.

3. You are not a U.S. citizen or resident, but are aged 42-64, and your yearly income is at or below 138% of the Federal Poverty Level.

Are you eligible for Medicaid? ☐Yes ☐No ☐Not sure

Demographics

What is your primary language?_____ ☐Prefer not to answer

Race

☐American Indiano/Alaska Native ☐Asian ☐Black/African American
☐Native Hawaiian/Pacific Islander ☐White/Caucasian ☐Prefer not to answer
☐Other

Ethnicity

☐Hispanic/Latino ☐Not Hispanic/Latino

Marital status

☐Single ☐Domestic Partner ☐Married ☐Widowed ☐Divorced ☐Separated

Does your Spouse/Domestic Partner work? ☐Yes ☐No ☐Other income

Gender identity
(please choose the option that best describes you, our system can only accept one)

☐Male ☐Female ☐Trans Male ☐Trans Female ☐Other ☐Prefer not to answer

Sex assigned at birth

☐Male ☐Female ☐Prefer not to answer ☐Unknown

Pronouns

☐he/him ☐she/her ☐they/them

Will you need an interpreter? (Spanish and Polish available)

☐Yes ☐No ☐I will come with my own interpreter

What is your preferred language for communications?

☐English ☐Spanish ☐Polish ☐No preference (communications will be in English)

What is the best way to contact you?

☐Phone call ☐Email/Athena Portal ☐Mail ☐No preference

Household Income Information

Are you currently employed?

☐Yes ☐No

↙ ↘

Employment status

☐Full time (35+ hours/week)
☐Part time (less than 35 hours/week)
☐Temporary
☐Seasonal
☐Other_____

How are you supported?

☐Spouse, friends, or family
☐Unemployment benefits
☐Social Security benefits
☐Savings or credit cards
☐Retirement/pension plan
☐Other_____

1. How often are you paid (per)?

☐Day ☐Week ☐Two weeks ☐Month ☐ Year (Income Tax)

2. Household Income amount (as listed on income documentation) $_____

3. Number of people supported (including you)?

☐1-just me ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐Other_____

Additional Questions

Do you need special assistance because of any of the following? (check all that apply)

Serious problems seeing: ☐Legally blind ☐Needs glasses
Serious problems hearing: ☐Hard of hearing ☐Deaf ☐Wears hearing aid
Difficulty reading: ☐In English ☐In native language ☐Both

How did you hear about CommunityHealth?

☐Onward House
☐Enlace
☐Consulate
☐Church
☐Community Outreach Event
☐Other Community Organization (Equal Hope, Chicago Street Medicine, etc.)
☐Internet Search
☐Social Media
☐Friend or Family Member
☐CommunityHealth website
☐From a CommunityHealth staff person
☐Rush Hospital
☐Northwestern Hospital
☐St. Anthony Hospital
☐Advocate Hospitals (IL Masonic, Lutheran General, Good Samaritan, etc.)
☐Wellness West
☐Media & Advertising (Radio, TV, Bus Ads)
☐Other _____

Can we contact you via WhatsApp if needed? ☐Yes ☐No

If yes, please provide your WhatsApp phone number: _____

Patient Consents

Consent for Treatment I hereby give my consent for treatment at CommunityHealth, and consent for CommunityHealth to securely share my medical information electronically, as part of the Health Information Exchange, with my care team members at outside health/hospital facilities. The Health Information Exchange allows health care professionals and patients to appropriately access and securely share a patient's medical information electronically.

Patient Responsibility I certify that the information contained in this registration form is accurate and truthful. By signing this intake form, I agree I will notify CommunityHealth in the event I have any insurance, and/or income change, and I also agree to update my information as it changes, and/or on an annual basis (as a minimum).

Medication Authorization I give my consent to release my information to Pharmaceutical Companies for auditing purposes in the Bulk Replacement Patient Assistance Program. I understand that I cannot request reimbursement for any prescription product received through this program from any government program or third-party insurer. I also consent to periodic chart audits by CommunityHealth staff/volunteers, and their partners.

Patient Signature_____ **Date**_____

Staff Signature_____ **Date**_____