Riley County Health Department
Registration Form

Patient Name (First) (Mid Init) (Last)

Social Security Number:

Primary Language: ___ English ___ Spanish ___ Other: ______________________

Birthdate:	Age:	Sex:	Marital Status:	Maiden Name:

RACE *(Check all that apply):*
_____American Indian/Alaska Native _____Asian
_____Black/African American _____Native Hawaiian/Other Pac Island
_____Unknown/Not Reported _____White

ETHNICITY *(Check only one):*
_____Non-Hispanic _____Hispanic Puerto Rican
_____Hispanic Mexican _____Hispanic Cuban
_____Hispanic Other/Unknown _____Hispanic So American

Current Address:
County______________________

Street:____Apt #_________

Po Box _____________

City/State___________________________________ Zip________________

Do you have a primary care physician? ____YES ______NO

If yes, who is your primary care physician?_______________________________________

Primary Phone#: Alt Phone#: Work Phone#:

Email Address:

CHECK ONE OF THE FOLLOWING:
_____You may contact me at the above address/ phone number(s)/email address.
_____You may **NOT** contact me at the above address and phone numbers. **Please contact me at:**

Parent or Guardian Name if client is a child: Relationship: Telephone:

Yes_____ No_____ Is patient 18 yrs old or YOUNGER, living at home with parents and DOES NOT WANT PARENTS TO KNOW OF SERVICES AT THIS CLINIC?
Yes_____ No_____ Is Patient a Student? If yes, Name of school or university:_____________________________________
Yes_____ No_____ Is patient eligible for military medical benefits (i.e., in the military, military dependent or has VA benefits)?
Yes_____ No_____ Is patient a migrant worker?
Yes_____ No_____ Does patient have any health insurance, to include Healthwave, Medicaid, or Medicare?
Yes_____ No_____ Are immunizations covered by your health insurance?
Yes_____ No_____ Do you want us to bill your insurance for services, if applicable? **If yes, please fill out the shaded area below**.

INSURANCE INFORMATION: Circle type(s) of coverage you have:

1	2	3	4	5	6
Medicare Part B/Medical	*Medicaid*	*Health Wave (Specify Below)*	*Other Public Insurance (Specify Below)*	*BCBS/Private Insurance*	No *Coverage*

Primary Insurance Carrier

Insurance Co. Name____ ID# ____________________________________ Group#__________

Policy Holder: (Name)______________________________________ (Birthdate)_______________ Patient relationship to policy holder____

Secondary Insurance Carrier

Insurance Name:____ ID#:________________________________ Group #_______________

Policy Holder: (Name)____ (Birthdate)_______________ Patient relationship to policy holder:_______

By my signature below, I authorize the Riley County Health Department to bill any of the medical payors (Insurance, Healthwave, Medicaid, etc) as indicated above and provide necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered and I understand I will be responsible for payment of charges for services deemed "uncovered" by Medicaid and/or my health insurance.

I hereby consent to the performance of examination and to any laboratory tests or medical procedure which may be necessary or advisable in the opinion of the healthcare staff of the Riley County Health Department. All records of services rendered are considered confidential. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KMAP, you may be held responsible for the charges, if your services are not covered by KMAP. You may also be responsible for charges if you fail to inform the Health Department of Medicaid/Healthwave coverage in a timely manner. The undersigned has read the above authorization and understands the same. I certify that the information provided on this page is true and correct to the best of my knowledge.

SIGNATURE______________________ DATE

Patient #___________________

Riley County Health Department
Financial Information

Pt #________________

NOTE: Financial information will be used to determine the amount to be charged for services or supplies. In addition, this information is pertinent to assessing the structure and needs of our community. All financial information is strictly confidential. No person shall be refused service for inability to pay. Services are provided without regard to religion, race, color, national origin, handicapping condition, gender, number of pregnancies, marital status, age or contraceptive preference.

Please list all information below for:

- Yourself **(DO NOT include "roommates")**
- Anyone you are financially responsible for who lives with you
- Anyone who is financially responsible for you who lives with you

Name of Household Member/ Relationship to Patient	Employer's Name/Address	How often paid?	Gross Income * Per Pay Period

☐ Total number in household

* The only exception to using gross income is using net income for family farms and other types of self-employment. Income includes the following: wages, salary, commissions, unemployment or workmen's compensation, public assistance money payments, alimony and child support payments, college and university scholarships, grants, fellowships and assistantships.

☐ I decline to give my income information. I understand that I will be charged full fees for the services I receive.

____ ______________________

Signature of patient (or parent/guardian) **Date**