



EASTERN SHORE RURAL HEALTH SYSTEM, INC. REGISTRATION FORM

Thank you for selecting our healthcare team! Eastern Shore Rural Health is *not just* a Doctor's office. We are a Community Health Center and we strive to provide you with the best possible healthcare. To help us meet all of your healthcare needs, please complete this form using blue or black ink.

For ESHRS Use Only:
Received by: _____
Translation: Y ___ N ___

If you have any questions or need assistance completing the form, please ask us and we will be happy to help you!

PATIENT INFORMATION

First Name : _____ Middle: _____ Last Name: _____
911 Address: _____ Town: _____
Mailing Address (P.O. Box): _____ Town: _____
State: _____ Zip: _____ Home Telephone: (____) _____
Social Security Number: _____ Birth date: ____/____/____
Race: African-American White Hispanic Other: _____ Gender: Male ___ Female ___
Marital Status: Single (S) Married (M) Divorced (D) Widowed (W) Legally Separated (X)
Have you completed an Advance Directive Form? Yes ___ No ___
Would you like to have an Advance Directive Form? Yes ___ No ___

RESPONSIBLE PARTY INFORMATION

Name of person responsible for payment on account: _____
Relationship to patient: Self ___ Spouse ___ Parent ___ Other ___
Date of Birth _____ Mailing Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____ Telephone Number (____) _____
Are you a migrant or seasonal farm worker? Yes No If yes, please circle one: Migrant Seasonal
Employment Status: Employed Full-Time (1) Employed Part-Time (2) Unemployed (3)
Self-Employed (4) Retired (5) Military Active Duty (6) Student (7)
Company Name: _____
Address: _____
Town: _____ State: _____ Zip: _____
Telephone: (____) _____ Fax: (____) _____

IN CASE OF EMERGENCY CONTACT

Name: _____
Telephone: (____) _____ Relationship: _____

HOUSEHOLD INCOME - *As a Community Health Center, programs may be available based on average incomes. Your household income determines if you qualify for our sliding fee program. This program offers a discounted fee schedule.*

Does your child qualify for free or reduced lunch at school? Yes ___ No ___ May we verify this with the school system? Yes ___ No ___

Does your annual income exceed \$50,000? Yes No
If No, does your income exceed \$35,000? Yes No
If No, does your income exceed \$25,000? Yes No
If No, does your income exceed \$15,000? Yes No
If No, does your income exceed \$10,000? Yes No

| Number of household members (including self) _____ | |
|--|----------------------|
| <u>Name</u> | <u>Date of Birth</u> |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

INSURANCE INFORMATION:

Name of Insured: _____
Relationship to Patient: _____ Insured's Birth date: _____
Insured's Employer: _____
Doctor listed on insurance card: _____

Primary Insurance

Insurance Company Name: _____
Effective Date: _____
Co-Pay: _____

Secondary Insurance

Insurance Company Name: _____
Effective Date: _____
Co-Pay: _____

Dental Insurance

Insurance Company Name: _____
Effective Date: _____
Id Number: _____

AUTHORIZATION AND RELEASE:

- A. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioner. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I accept full responsibility for any legal or collection agency fees, not to exceed 40% should my account become delinquent.
- B. I authorize Eastern Shore Rural Health System, Inc. through its appropriate personnel and/or medical staff to perform, administer, prescribe or have performed, administered or prescribed upon: to me or for me or any member of my family (including minor children) whose names appear above, such examinations, tests, immunizations, injections and diagnostic procedures as are deemed. I also certify that all information contained herein is true and correct to the best of my knowledge and believe that no facts have been omitted.
- C. Section 32.1-45 of the Virginia Code provides that whenever any Physician or any person employed by (or under the direction and control of) Hospital or Physicians is directly exposed to Patient's body fluid in a manner that may, according to the then current guideline of the Center for Disease Control, transmit human immunodeficiency virus (the AIDS virus), Patient will be deemed to have consented to testing for infection with the AIDS virus without his or her actual consent. The results of this test may be released to the person who was exposed to Patient's body fluids, also without Patient's actual consent.

X _____ Date: _____
Signature of patient or parent/guardian for minor