Horizon
Health And Wellness

Health Center
Registration Form

Patient Information: **Date:** _____/_____/_____

Patient Name: _____ _____ _____

(Last Name) (First Name) (Middle Name)

Gender: ☐Male ☐Female ☐Transgender

Date of Birth: _____ /_____ /_____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Contact Phone: _____ Message Phone: _____

Emergency Contact Information:

Name: _____ Phone Number: _____

Address: _____City: _____Zip Code: _____

Relationship to Patient: _____

Pharmacy Information:

Pharmacy Name: _____ Address or Cross Streets: _____

Insurance Information: **(Please present your insurance card to front office staff)**

Name of responsible Person: _____ DOB: _____/_____/_____

(Only If Patient is a Minor or NOT the Subscriber) SSN (Required): _____

Primary Insurance Company: _____ Subscriber: ☐Yes ☐No

Policy ID: _____ Group #: _____

Policy Holder's Name: _____ Subscriber DOB: _____/_____/_____

Relationship to patient: _____ Subscriber SSN: _____

Secondary Insurance Company: _____ Subscriber: ☐Yes ☐No

Policy ID: _____ Group #: _____

Policy Holder's Name: _____ Subscriber DOB: _____/_____/_____

Relationship to patient: _____ Subscriber SSN: _____

Preferred Method of Communication: ☐ Mail ☐ Phone ☐ Patient Portal (Email address required)

Email address: _____

Preferred language: _____

Do you want access to your medical information online through our patient portal? ☐ Yes ☐ No

Additional Patient Information:

Race:
☐American Indian or Alaska Native ☐Asian ☐Other Pacific Islander
☐Native Hawaiian ☐White ☐Black or African American
☐More than one race ☐I do not want to disclose

Ethnicity:
☐Hispanic or Latino
☐Not Hispanic or Latino
☐I do not want to disclose

Are you a Veteran? ☐Yes ☐No

Do you live in Public Housing? ☐Yes ☐No

Are you Homeless? ☐Yes ☐No
If Yes: ☐Doubling up ☐Shelter ☐Street ☐Transitional ☐Other: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner

Number of people in patient's household: _____

Monthly Income: _____ (or) Annual Income: _____ ☐I do not want to disclose my income

Employment Information:

Employer: _____ Occupation: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Work Phone: _____ Employment Status: _____

Consent for Treatment: The above information is true to the best of my knowledge. I hereby and voluntarily consent to treatment and care by Horizon Health and Wellness. I understand that my treatment and care may include routine care, laboratory testing, and a variety of other medical services considered medically necessary. By signing below I am giving consent for any medical treatment or procedure deemed necessary by the professional staff of Horizon Health and Wellness.

_____

Print Name

_____ _____

Signature **Date**