Southern Dominion Health System, Inc.

PATIENT REGISTRATION FORM
Please Fill In All Information

PATIENT INFORMATION (PLEASE PRINT)

Date of Birth: | **Social Security Number:**

Patient's Last name: **First:** **Middle:** | **Marital status:** ❑Single ❑Married ❑Divorced ❑ Separated ❑Widow

Race: ❑ American Indian ❑ Asian ❑ Black/African American ❑ Caucasian(White) ❑ Other Pacific Islander ❑ Native Hawaiian ❑ American Indian/Alaska Native | **Pharmacy:** | **Sex:** ❑ M ❑ F

Ethnicity: ❑ Hispanic/Latina(o) ❑ Non-Hispanic/Latina(o) ❑ Refuse to Report

Mailing Address: **Email Address:**

City: **State:** **ZIP Code:** | **Home Phone Number:** ( )

Preferred SDHS Provider: | **Cellular Phone Number:** ( )

Seasonal Worker: ❑ Yes ❑ No | **Migrant Worker:** ❑ Yes ❑ No | **Homeless:** ❑ Yes ❑ No

Is the patient employed: ❑ Yes ❑ No
❑ Full-time ❑ Part-time ❑ Student
Name of Employer:_____
Address:_____
_____
Phone: _____

Is the Patient a Veteran?
❑ Yes ❑ No

Native Language: ❑ English ❑ Spanish ❑ French
❑ Other, please list:_____

Primary Care Physician:

If under 18, Parent/Guardian/Guarantor Name: | **Parent/Guardian/Guarantor Employer:** | **Employer phone number:** ( )

Parent/Guardian/Guarantor Address, City, State, Zip: **Birthdate:** **SS#** **Phone #**

EMERGENCY CONTACT, IN CASE OF EMERGENCY NAME OF PERSON WE CAN CONTACT:

NAME:
PHONE NUMBER:
RELATIONSHIP TO PATIENT: ❑ Spouse ❑ Child ❑ Parent ❑ Other_____

Income Verification: *(As a Federally Qualified Health Center, we are required to ask this information for reporting purposes).*

Please check the box that pertains your family's annual income.

❑ Greater than $50,000 ❑ $35,000-49,999 ❑ $25,000-34,999

❑ $15,000-24,999 ❑ $10,000-14,999 ❑ Less than $10,000

Number of household members supported by this income: _____

Patient Information	
Patient Name:	DOB:

Authorization and Release:

A. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to the patient (myself or my minor child or ward herein named) during the period of such care to third party payers (including insurance companies). I authorize and request third party payers (including insurance companies) to pay directly to the doctor or doctor's group benefits otherwise payable to me. I understand that my third-party payers (including insurance companies) may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to patient. I accept full responsibility for any legal or collection agency fees, not to exceed 40% should my account become delinquent.

B. I authorize Southern Dominion Health System, Inc. (SDHS) through its appropriate personnel and/or medical staff to perform, administer, or prescribe such examinations, tests, immunizations, injections and diagnostic procedures as are deemed necessary. I have the right to decline treatment. 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. I am aware that 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) Physician is directly exposed to Patient's body fluid in a manner that may 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.

Protected Health Information (PHI) Patient Consent:

SDHS provides this section to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). SDHS will protect PHI in accordance with HIPAA regulations.

D. I understand the SDHS Notice of Privacy Practices (NPP) provides information about how SDHS may use and disclose protected health information (PHI) about the patient. I have had the opportunity to review this notice. The NPP contains a Patients' Rights section describing patient rights under the law. SDHS reserves the right to change the NPP. If SDHS changes the notice, I may obtain a revised copy by contacting SDHS.

E. I consent to SDHS' use and disclosure of PHI about the patient from treatment, payment, and health care operations. Examples of health care operations include, but are not limited to, prescriptions, laboratory, x-ray, referrals, electronic health information data exchange and consults with other health care providers. I have the right to restrict or revoke this consent, in writing; however, such a request shall not affect any disclosure SDHS has made in prior consent. Restrictions may negatively affect the timeliness of care. SDHS is not required to comply with all restrict or revoke requests.

F. I authorize SDHS to request and receive any records held by the Virginia Department of Health Professions or other appropriate state programs relating to Schedule II-V controlled substances dispensed to the patient.

G. I consent to receive messages from SDHS that utilize an automatic telephone dialing system to deliver a text, voice, or pre-recorded message that may contain health related information or healthcare management advice at the telephone number(s) that I have provided. I may request SDHS to adjust my communication preferences at any time.

H. Guardianship: If applicable, I understand that I am the legal guardian of this patient and have provided official documentation to SDHS.

I. If applicable: I authorize the release of all PHI about the patient to the following individuals(s) as well as allow them to participate in patient care activities (i.e. transport to and from appointment, assist in examinations, etc.) and consent to treatment as deemed necessary (examinations, tests, immunizations, injections and diagnostic procedures). I am responsible for notifying SDHS if I wish to revoke these privileges. Privileges are only applicable for one year from signature date.

Name:	Relationship:	Phone:

Staff will not make disclosures to any family member or friend not listed above

Signature of Patient or Parent/Guardian of Minor **Printed Name** **Date**