



**Loudoun
Community
HEALTH CENTER**

Your Home for Quality Health Care

Patient Registration Form

Today's date: _____

Patient's Name: _____

Date of birth: _____ Sex: M / F Social Security Number: _____ - _____ - _____

Address: _____
(Street) (City/State/Zip)

Home phone: _____ Cell phone: _____ E-mail: _____

How would you prefer to be contacted for appointment reminders? Phone Text Message E-mail

Marital Status: Married Single Divorced Widowed

Check all that apply: Veteran Migrant-seasonal agricultural worker Homeless

Race: (check one) Black/African-American White Asian Native Hawaiian

Pacific Islander American-Indian/Alaska Native More Than One Race Refuse to report

Ethnicity: (circle one) Non-Hispanic Hispanic

Primary Language: _____ Do you need a translator? Yes / No

Employment status: Full-time Part-time Unemployed

Self-employed Retired Military active duty

Employer: _____

Employer address: _____ Employer phone: _____

Person Responsible for Payment: _____

Relationship to patient: (circle one) Self / Spouse / Parent

Address (if different from patient's) _____
(Street) (City/State/Zip)

Home phone: _____ Cell phone: _____

In Case of Emergency Contact:

Name: _____ Telephone: _____

Relationship to patient: _____

INSURANCE INFORMATION: Private Insurance Medicaid/FAMIS Medicare Other

Name of Insured: _____

Relationship to patient: self / parent / spouse Insured's birth date: _____

Insurance Plan: _____ Address: _____

ID Number: _____ Group Number: _____

Doctor listed on insurance card: _____

Please present your insurance card every time you check in.

ADVANCED DIRECTIVE: An Advance Directive allows you to state your choices for health care or to name someone to make those choices for you if you become unable to make decisions about your medical treatment. It enables you to say "yes" to treatment you want, or "no" to treatment you do not want. We can provide you with a form to fill out if you need one. **Do you have an Advanced Directive? Yes / No**

SLIDING FEE DISCOUNT PROGRAM: The Loudoun Community Health Center offers a Sliding Fee Discount Program that reduces fees for qualified patients. As a nonprofit organization, we are able to offer this very special program because we are supported in part through the generous support of individual donors, philanthropic foundations and government grants. This support does not cover the full cost of the wide range of services we provide, so patient payments are vital to our continuing ability to provide your care. Our services are discounted for our low-income patients on a sliding fee scale based on the number of people living in a household and their combined incomes. **If you think you may be eligible and would like to apply for our sliding fee discount program, please ask a staff member to provide you with an application.**

I acknowledge under penalty of the law that all information provided on this form is true. I authorize the release of any information necessary to process this bill to my insurance company and request payment of benefits to the Loudoun Community Health Center. I acknowledge that I am responsible for payment whether or not covered by insurance.

Signature of person responsible for payment: _____ Date: _____