Orange Blossom Family Health Center
PATIENT REGISTRATION FORM AND SELF DECLARATION FORM

Fee Scale:

Section 1: Patient Information (Please print clearly)

Name:		Today's Date:
SSN:	Date of Birth:	Sex: ❑ Male ❑ Female
Address/Shelter:		
City:	Zip Code:	Phone:
Preferred Method of Communication: ❑ Home Phone ❑Work Phone ❑ Cell Phone ❑ Leave Message at Shelter ❑ Mail		
Marital Status: ❑ Single ❑Married ❑ Divorced ❑ Separated ❑ Widowed Are you homeless? ❑ YES ❑ NO Do you live with a friend or family member: ❑ YES ❑ NO **If yes, this is due to:** ❑ Eviction ❑ Job Loss Other: _____	Preferred Language: ❑ English ❑ Spanish ❑ Creole ❑ Other: _____ Do you need an interpreter? ❑ No ❑ Yes, for _____	
Emergency Contact Name:_____ Emergency Contact Phone #: Relationship to Patient: Preferred Language: ❑ English ❑ Spanish ❑ Creole ❑ Other: _____		
Race: (Please check one) ❑ White ❑ Black (non Hispanic) ❑ Hispanic (Black) ❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ Pacific Islander ❑ Haitian Black ❑ Haitian Hispanic ❑ Haitian White ❑ Hispanic (White)		

Section 2: Financial Information

1. Do you have medical or dental insurance for this illness/condition?	❑YES ❑NO
2. Are you a United States Citizen?	❑YES ❑NO
3. Are you a veteran?	❑YES ❑NO
4. Do you receive Social Security benefits, SSI, disability or VA pension?	❑YES ❑NO
5. Please select your living arrangements from the following options: ❑ Home/Apartment ❑ Street ❑ Car ❑ Shelter ❑ Hotel/Motel ❑ Substance Abuse Treatment Center ❑ Other _____ How long? _____	

Section 3: Family Information

Family Type: ❑ Married w/children ❑ Married w/o children ❑ Single w/children ❑ Single w/o children ❑ Other			
Number in family	Adults:	Under 18:	TOTAL:
HOUSEHOLD INCOME TOTALS			

Section 4: Statement of Accuracy & Notice of Privacy

I affirm, by my signature on this form, that the information I have provided is true and correct, to the best of my knowledge. I acknowledge that the information given is subject to verification by the Bureau of Primary Health Care, Orange County, and the State of Florida Department of Health. I understand it is my responsibility to inform the Orange Blossom Family Health Center of any changes to this information prior to, or at my next visit. I am also responsible for providing documentation of residency, identity, insurance, and income if not available at this time. I understand that giving false or inaccurate information may make me ineligible for primary care services provided by the clinic. By signing this document below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient/Parent or Guardian *Witness*

Date: _____ Date: _____

Eligibility Expires on: _____