SOUTHWEST CARE

Patient Registration Form

Please print «encDate»

Patient Information				
Last Name		First Name		Middle Initial
Nickname		Social Security Number		Email Address
Date of Birth	Age	Sex at Birth ☐ Male ☐ Female ☐ Other ☐ Decline to Answer		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner ☐ Legally Separated				
Employment Status ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Military				
Veteran ☐ Yes ☐ No ☐ Decline to Answer				
Seasonal/Migrant Work Status ☐ Yes ☐ No ☐ Decline to Answer				
Mailing Address Street:		City:	State:	Zip Code:
Physical Address (if different) Street:		City:	State:	Zip Code:
Primary Phone ☐ Home ☐ Cell (_____) _____ - _____ OK to leave messages at this number? ☐ Yes ☐ No ☐ Preferred				
Additional Phone ☐ Home ☐ Cell (_____) _____ - _____ OK to leave messages at this number? ☐ Yes ☐ No ☐ Preferred				
Work Phone (_____) _____ - _____ OK to leave messages at this number? ☐ Yes ☐ No ☐ Preferred				
Responsible Party/Guardian Information (if other than self or under age 18)				
Name		Phone Number (_____) _____ - _____		Relationship to Patient
Address Street:		City:	State:	Zip Code:
Emergency Contact Information				
Name		Phone Number (_____) _____ - _____		Relationship to Patient
Address Street:		City:	State:	Zip Code:
Is Emergency Contact legal guardian? ☐ Yes ☐ No				

Insurance Information	**Primary Insurance**	**Secondary Insurance**	**Tertiary Insurance**
Carrier Name:			

Carrier Address:			
Subscriber Name:			
Identification Number:			
Group Number:			

Primary Care Provider	
First and Last Name	Phone Number (_____) _____ - _____
Clinic Name	Fax Number (_____) _____ - _____

Referring Provider	
First and Last Name	Phone Number (_____) _____ - _____
Clinic Name	Fax Number (_____) _____ - _____

Preferred Pharmacy	
Name	Phone Number (_____) _____ - _____
Address	Fax Number (_____) _____ - _____

Preferred Laboratory	
Name	Phone Number (_____) _____ - _____
Address	Fax Number (_____) _____ - _____

Additional Information

Southwest CARE Center offers assistance in applying for New Mexico Medicaid coverage and offers a sliding scale fee for individuals whose income falls below 200% of the federal poverty level.

Are you interested in speaking with an eligibility specialist? ☐ Yes ☐ No

Do you have an Advance Directive? ☐ Yes ☐ No (If Yes, please provide a copy of your directive at your next appointment.)

☐ I decline to share the information listed below

Race:
☐ American Indian or Alaskan Native
☐ Asian
- ☐ Asian Indian ☐ Filipino ☐ Korean ☐ Other Asian
- ☐ Chinese ☐ Japanese ☐ Vietnamese

☐ Hawaiian
- ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

☐ Black or African American
☐ White/Caucasian ☐ Other _____

Ethnicity:
☐ Not Hispanic ☐ Hispanic
- ☐ Mexican, Mexican American, Chicano ☐ Cuban

□ Puerto Rican □ Another Hispanic, Latino or Spanish origin

Primary Language: _____ Preferred Language: _____

Do you need a translator? ☐ Yes ☐ No ☐ Preferred

For the purposes of SCC's reporting obligations to our funding sources, please list your Household Size and estimated Annual Household Income (including income from all household members living with you).

Household Size: _____ Annual Household Income: _____

Patient Signature

I hereby acknowledge that all information given is accurate and true to the best of my knowledge.

__
Print Name

X_____ _____

Patient or Guardian Signature Date

If not signed by the patient, please indicate your relationship to the patient: _____

Acknowledgements

Consent to Treat:
I consent to receiving necessary health services and treatment from authorized providers at Southwest CARE Center. I authorize all providers at Southwest CARE Center to access my medical records and information as needed for my medical care. As a client of Southwest CARE Center, I understand that I am voluntarily receiving services from Southwest CARE and that I have certain rights, including the right to confidential records and visits. I also certify that the information I provided on this document is true and correct to the best of my knowledge. I will notify Southwest CARE Center of any changes in the information contained in this history.

Assignment of Benefits:
I hereby instruct my insurance carrier(s) to make payment as a direct assignment of my rights and benefits under my policy to Southwest CARE Center. I also authorize the release of any information pertinent to my case to my insurance carrier(s). A photocopy of the assignment and release shall be considered as effective and valid as the original.

Financial Agreement:
I understand that I am responsible for all charges not paid by my insurance company(s). I further understand that payment, co-payment and deductibles for all office services are due at the time services are rendered. Payment for services for which I receive an invoice are due and payable within 30 days. I request and authorize outpatient care, as my physician, his/her assistant or designee may deem necessary or advisable. In addition, I understand Southwest CARE Center is not responsible for any ancillary (for example, labs and radiology) services ordered by our physicians.

Referrals:
If my insurance company (including Medicaid) requires a referral, it is my responsibility to obtain this referral from my primary care physician prior to my first medical appointment. In the event that I choose to be seen without a referral, I understand that I will be responsible for all charges associated with services rendered.

Pharmacy Services:
Southwest CARE Center offers pharmacy services. I understand I am not obligated to use these services.

Multi-Disciplinary Team Participation:
Southwest CARE Center utilizes a multi-disciplinary team approach to care and services. Medical or Social information pertinent to your care may be shared across disciplines.

Emergency Contact:
I understand that in the event of an emergency, the contact person I have listed on this form may be notified.

I hereby acknowledge the agreement of understanding: Consent to Treat, Assignment of Benefits, Financial Agreement, Referrals, Pharmacy Services, Multi-Disciplinary Team Participation, and Emergency Contact.

_«FirstName» «LastName»_____
Print Name

X_____ _____

Patient or Guardian Signature	Date
If not signed by the patient, please indicate your relationship to the patient: _____	