**Date:**

**Patient Registration Form**

**How did you hear about us?** Internet search Social Media Flyer Banner Website Radio TV Community Fair Referral Newspaper Magazine Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Info**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthdate**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security#**:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address Line**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City, State, Zip code**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy**

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Demographics**

**Marital Status**: Single Married Divorced Separated Widow

**Gender:** Male Female Transgender Male/ Female-to-Male Transgender Female/Male–to Female Other Choose not to Disclose

**Sexual Orientation**: Lesbian/gay Straight Bisexual Other Don‘t know Choose not to Disclose

**Primary Language**: English Spanish French Other

**Race**: African American Caucasian Asian Native American Other

**Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

**Do you have health insurance**? Yes No if yes: Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_ Subscriber ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Consent for Treatment**

By signing below, you give St. Gabriel Health Clinic Inc. permission to treat you. Treatment may include, but is not limited to routine diagnostic procedures, examination and medical treatment (examples: laboratory work, X-rays, ECG/EKG, medication administration etc.). Medical treatment, diagnostic procedures, and exams may be rendered by St. Gabriel Health Clinic, Inc.’ s medical staff, their assistants, and other designees deemed qualified by the medical staff. The St. Gabriel Health Clinic, Inc. may release your medical information to its third party insurance carriers for filing purposes and to those who have designated and authorized as recipients of your medical information. This consent will be valid and remain in effect as long as you are a patient of St. Gabriel Health Clinic Inc. Please only sign this consent form if you fully understand its contents.

Signature of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Request and Release of Medical Information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#/ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_**

**I Authorize:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Person or facility which has health information)*

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_**

**Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To Release Health Information to:**

**St. Gabriel Health Clinic Gardere Center for Primary Care Services**

**5760 Monticello Dr. 1707 Gardere Lane**

**St. Gabriel, LA 70776 Baton Rouge, LA 70810**

**Phone (225) 642-9676 225-930-4922 office**

**Fax (225) 642-9696 225-930-4926 fax**

**Information to be released-covering the periods of health care**

**From (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please specify the type of health information you authorize to be released:**

**Limitations upon disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*The purpose of this release is: at the patient’s request, this information will be used to update the patient’s record at St. Gabriel Health Clinic/Gardere Center for Primary Care Services, prevent duplication in care and to aid in diagnosis and treatment.*

**I hereby consent to release my HIV test results:\_\_\_\_\_\_\_\_ (Initial) I have the right to refuse to release my HIV test results, except where release is authorized by law without my consent.**

**I hereby consent NOT to release my HIV test results:\_\_\_\_\_\_\_\_ (Initial) I have the right to refuse to release my HIV test results, except where release is authorized by law without my consent.**

**Expiration of Authorization**

**Unless otherwise revoked, this authorization expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If no date is indicated, the authorization will expire 12 months after the date of my signing this form.**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*You have a right to a copy of this authorization and to revoke it at your discretion\*\***

**Name**:

**Date**:

**DOB**:

**# of Household Members**:

**Household Assessment:** Household Information must be completed for all patients

**Name: Date of Birth:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Sliding Fee Application**

**The following Sliding Fee Application must be completed for all patients:**

Please consider all sources of income including: Employment wages, self-employment wages, tips, unemployment benefits,

Under-employment benefits, social security, child support, public assistance, etc.

**Employer or self-employed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gross Wages per pay period**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **how often are you paid**? Daily Weekly Bi-weekly Twice per month Monthly

**Household Income**: (Proof of income must be copied and attached)

**If unemployed, list your primary source of income**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Amount**: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Frequency of payments**: Daily Weekly Bi-weekly

Twice per month Monthly

**Applicant Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Upon Approval, this application is valid for a period of one year and must be renewed.

**Expiration Date 6 months from Application Date):**\_\_\_\_\_\_\_\_**Staff Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Self-Declaration Form**

**Patient Information**

Patient’s Name: Birthdate:

Address: City, State, Zip code:

Phone Number

**Declaration of Employment**

I declare that my principle

Employment is in and that presently: □I am working, □I am not working

Employer Name:

Employer Address:

**Declaration of Income and Family size**

I declare that my household income for last year was $ and that my monthly family income is $ I also certify that a total of people, including spouse, children, parents, grandparent, etc. are living in my household

I certify that the information that I provided is correct and I authorize the Health Center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a temporary discount for health services for 6 months.

I understand that if I do not provide the required documentation, I can continue to receive my health care services at this center but I will have to pay 100% of my medical bill.

Applicant Signature: Date: