SUNSET HEALTH

PATIENT REGISTRATION

Patient Information

Last Name	First Name	Middle	Preferred Name

SSN	Birth Date	Birth Sex
		☐ Female ☐ Male ☐ Undifferentiated

Mailing Address	Apt/Suite	Cell Phone

City	State	ZIP	Home Phone

Home Address (if different)	Apt/Suite	Alternate Phone

City	State	ZIP	Email Address

Marital Status
☐ Annulled ☐ Life Partner
☐ Divorced ☐ Married
☐ Domestic Partner ☐ Single
☐ Legally Separated ☐ Widowed

Student Status
☐ Full-Time Student
☐ Not a Student
☐ Part-Time Student

Preferred Language
☐ English
☐ Spanish
☐ Other: _____

Interpreter Needed?
☐ Yes ☐ No

Employment Status	Employer Name:	Preferred Pharmacy & Location
☐ Self Employed ☐ Employed ☐ Not Employed ☐ Veteran		

Emergency Contact

Name	Relationship to Patient	Phone

We are requesting the following information in order to understand our patient needs better, to help our staff use the most respectful language when addressing you, and for funding purposes that may help reduce the cost of your healthcare.

Current Gender
☐ Female
☐ Male
☐ Undifferentiated

Gender Identity
☐ Female
☐ Male
☐ Female-to-Male/Transgender
☐ Male-to-Female/Transgender
☐ Genderqueer
☐ Other
☐ Choose not to disclose

Sexual Orientation
☐ Straight
☐ Lesbian or Gay
☐ Bisexual
☐ Something else
☐ Don't know
☐ Choose not to disclose

Preferred Pronoun
☐ She, Her, Hers
☐ He, Him, His
☐ They, Them, Theirs
☐ Ze, Hir
☐ Other
☐ Decline to Answer

Religion
☐ Catholic ☐ Muslim
☐ Christian ☐ Other
☐ Hindu ☐ None
☐ Jehovah Witness
☐ Mormon
☐ Choose not to disclose

Housing Status
☐ Not Homeless (rent/own)
☐ Shelter
☐ Transitional
☐ Doubling Up (with friend/relative)
☐ Street (also car/camp/tent)
☐ Other
☐ Assisted Living/Nursing Home

Race
☐ American Indian/Alaska Native
☐ Asian Indian
☐ Asian: Chinese
☐ Asian: Filipino
☐ Asian: Japanese
☐ Asian: Korean
☐ Asian: Vietnamese
☐ Asian: Other Asian
☐ Black/African American
☐ NH/PI: Guamanian or Chamorro
☐ NH/PI: Native Hawaiian
☐ NH/PI: Other Pacific Islander
☐ NH/PI: Samoan
☐ White

Ethnicity - (check only one)
☐ Hispanic: Mexican, Mex/Amer, Chicano/a
☐ Hispanic: Puerto Rican
☐ Hispanic: Cuban
☐ Hispanic: Oth Hispanic Latino/a, Spanish
☐ Not Hispanic

Public Housing	Head of Household	DOB ☐ Self	Number of Family Members	Income ☐ Per Month $ _____ ☐ Per Year
☐ Yes ☐ No				

1) In the past 2 years, have you or a member of your family worked in agriculture/farming including: • Preparing, irrigating or spraying the fields, nurseries, orchards; • Planting, picking, sorting, packing, or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay, or other agricultural products; • Planting trees; working with Christmas trees; picking pine needles or Spanish moss; • Working on farms that produce chickens, ducks, turkeys, cows, goats, sheep, horses, fish, seafood, etc.	**Yes ☐** (GO to question 3-4) **No ☐** (GO to question 2)
2) Have you or a member of your family stopped migrating to work in agriculture because of a disability or old age?	**Yes ☐** (GO to question 3-4) **No ☐** (STOP)
3) Have you or a member of your family established a temporary home in order to work in agriculture?	**Yes ☐** (STOP) **No ☐** (CONTINUE to question 4)
4) Have you or a member of your family worked in agriculture on a seasonal basis without the need to move away from your home?	**Yes ☐** **No ☐**

PATIENT REGISTRATION

Responsible Party	Parent/Guardian Information – Please complete if patient is under 18 years of age		
☐	Mother's Name	Birth Date	SSN
☐	Father's Name	Birth Date	SSN
☐	Guardian's Name	Birth Date	SSN

Insurance Information

Primary Insurance Name		Policy #
Name of Insurance Holder ☐ Same as Patient		Group#
DOB of Insurance Holder	SSN of Insurance Holder	Patient's Relationship to Insurance Holder ☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Insurance Name		Policy #
Name of Insurance Holder ☐ Same as Patient		Group#
DOB of Insurance Holder	SSN of Insurance Holder	Patient's Relationship to Insurance Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Notice of Privacy Practices / Consent to Treat / Release of Information

- I authorize Sunset Health to disclose limited protected health information to other persons who may answer electronic communication such as phone, text messages, or e-mail. Initial _____
- I acknowledge that I have read and understand the HIPAA Notice of Privacy Practices for the Sunset Health dated 01/01/2020. This notice provides information about my rights with regards to my health care information and how the Sunset Health will use and disclose my health care information. My initials and signature on this form acknowledges that I have been offered and/or received a copy of Sunset Health's Notice of Privacy Practices. Initial _____
- I understand information may be released without my consent in case of a medical emergency, abuse or neglect and where legally required. I agree to participate in my treatment planning and assessment process to the best of my ability. There is no guarantee that those treatment services deemed medically necessary as a result of the assessment will prove beneficial to me. Furthermore I understand that my treatment may be provided by a professional or technician who is operating under direct clinical supervision, or oversight. Initial _____
- My initials on this form acknowledge that I understand my patient Rights and Responsibilities posted at any Sunset Health and that I have access to a copy of these Rights and Responsibilities upon request. Initial _____
- My initials on this form acknowledge that I received the Notice of Health Information Practices with which Sunset Health participates. This notice provides information about how the Health Information Exchange (HIE) works and my rights regarding HIE under state and federal laws. I have access to a copy to this notice and my rights upon request. Initial _____
- I consent to the rendering of care and medical/dental/behavioral health treatment, including diagnostic procedures and routine emergency medical/dental/behavioral health care by authorized clinic personnel as may, in their professional judgement, be necessary for the health of myself and/or my family. This consent will remain in effect until such time as it is revoked in writing. Initial _____
- To assist in preventing and detecting identity theft of personal information, I agree to have my picture or my child's picture taken, or to provide a password, for the medical account. Initial _____
- I authorize the release of any of my protected health information to my insurance carrier or other payer, as needed for the purpose of obtaining payment for services provided by Sunset Health. Initial _____
- I have received a copy of "How to Call the Clinician When the Clinic is Closed and understand I have access to care after hours. Initial _____
- I have received information regarding Advance Directive and my options for establishing advance directives and/or power of attorney. Initial _____
- Recording, Taping, and Photography are prohibited during any appointment to protect the safety and privacy of the patient. Initial _____

Signature of Authorization & Financial Responsibility

I acknowledge my responsibility to pay for care and/or treatment according to the fees established. Furthermore, I authorize assignment of benefits for medical and/or dental and/or behavioral services to Sunset Health.

Signature of Patient or Parent/Legal Guardian	Date