Navarro County Ambulatory Care Association
Dr. Kent E. Rogers Clinic
618 North Main Street Corsicana, TX 75110
903-874-6731*903-872-0126

PATIENT REGISTRATION FORM

SECTION I: PATIENT INFORMATION (please print in all sections of the document)

Last Name: | First Name: | Middle Initial: | Suffix:

Street Address: | City: | Zip:

County: | Date of birth: | Social Security Number:

Cell/Primary Phone: | May we leave message? □ Yes □ No | Would you like to receive text messages? □ Yes □ No

Work Phone: | May we leave message? □ Yes □ No | Alternate Phone:

Email: | Preferred method of contact: □ Phone □ Text □ Email □ Patient Portal

Is the Patient a minor (under 18 yrs. old)? □ Yes, **if yes, complete Section II** □ No, **if no, skip Section II**
(note: If the Patient is under 18 yrs. old and is emancipated by the court, skip to Section III. Legal documentation is required)

SECTION II: PARENT/GUARDIAN INFO (complete this section **only if the patient is a minor, under 18 yrs. old.)**

Custodial Parent or Legal Guardian (REQUIRED)

Last Name: | First Name: | Date of birth:

Street Address: | City: | Zip: | County:

Cell/Primary Phone: | May we leave message: □ Yes □ No | Social Security Number:

Relationship to Patient: □ Custodial Parent □ Legal Guardian (if patient is under Legal Guardianship, legal documentation is required)

Non-Custodial Parent (if applicable)

Last Name: | First Name: | Date of birth:

Street Address: | City: | Zip: | County:

Cell/Primary Phone: | May we leave message: □ Yes □ No | Social Security Number:

SECTION III: PATIENT DEMOGRAPHICS

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Choose not to disclose

Name of Spouse/Partner (if applicable): | **Spouse/Partner's Phone:**

Current Gender: □ Female □ Male □ Undifferentiated □ Unknown

Gender Identity: □ Female □ Male □ Transgender □ Choose not to disclose □ Other

Sexual Orientation: □ Straight □ Lesbian, Gay or Homosexual □ Bisexual □ Unknown □ Choose not to disclose □ Something Else ______

Preferred Pronoun: □ She, Her, Hers □ He, Him, His □ They, Them, Theirs □ Ze, Hir □ Other □ Choose not to disclose

Homeless Status: □ Not Homeless □ Shelter □ Street □ Transitional □ Unknown/Unreported

Race (please check all that apply):

□ Asian □ Asian Indian □ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Samoan □ Other Pacific Islander

□ Native Hawaiian □ Guamanian or Chamorro □ Black/African American □ White □ American Indian/Alaska Native

□ Other Asian □ More than one race □ Choose not to disclose

Ethnicity:
□ Mexican □ Mexican American □ Chicano/a □ Puerto Rican □ Hispanic or Latino/a □ Cuban □ Not Hispanic or Latin/a

□ Unknown □ Choose not to disclose

Student Status: □ Full-Time □ Part-Time □ Not a Student

Preferred Language (example: English, Spanish): ______________________________ | **Do you need a translator?** □ Yes □ No

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Employment: ◻ Not Employed ◻ Retired ◻ Full Time ◻ Part-Time	Employer Name:	Phone Number:

Migrant Worker Status: ◻ Migrant ◻ Not a Farm Worker ◻ Seasonal	**Are you a Veteran?** ◻ Yes ◻ No

SECTION IV: FINANCIALLY RESPONSIBLE PARTY (GUARANTOR)

Name of person financially responsible for patient:		Relationship: ◻ Self ◻ Parent/Guardian ◻ Spouse
Streer Address:	City:	Zip:
DOB:	Primary Phone:	Social Security Number:

SECTION V: INSURANCE INFORMATION

Do you have Insurance? ◻ Yes ◻ No ◻ Unsure

If you answered Yes, please check & complete all that apply:

◻ Private
Name of Insurance Company: ______________________ Subcriber's Name ______________________ DOB ________

◻ Secondary Private
Name of Insurance Company: ______________________Subcriber's Name______________________ DOB ________

◻ Medicare
Medicare Number: ______________________ Do you have Medicare Secondary Insurance? ◻ **Yes** ◻ **No**

If yes, Medicare Secondary Insurance Name: ______________________ Medicare Secondary Policy #: ______________________

◻ Medicaid
Medicaid Plan: ______________________ Medicaid Number: ______________________

SECTION VI: EMERGENCY CONTACT INFORMATION (at least one emergency contact is required

Name of friend or relative:	Relationship:	Phone:
Name of friend or relative:	Relationship:	Phone:

SECTION VII: REASON FOR VISIT

Please describe the reason for your visit:

____

Are you pregnant? ◻ Yes ◻ No

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to Navarro County Ambulatory Care Association, dba Dr. Kent E. Rogers Clinic, for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient Signature

______________________________ ______________________

Patient *or* Parent/Guardian Signature (if patient is under 18 years old) **Date**

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Application for Program Benefits

All information is strictly confidential

Dr Kent E. Rogers Clinic offers discounted services based on financial ability or inability to pay. This program requires us to obtain income and household information from each patient for whom we provide services. If you qualify, you will pay a discounted amount for care. Please initial below if you are applying for the Sliding Fee Scale or do not wish to be considered.

☐ I wish to be considered for the Sliding Fee Scale and will complete Application for Program Benefits and provide all required Household income and information. I understand that failure to submit all the required information, will delay in the determination of discounted services.

Patients declining to be considered for the Sliding Fee Scale do not need to submit income and household information. In addition, you may skip the remainder of the Application for Program Benefits.

☐ I <u>do not</u> wish to be considered for the Sliding Fee Scale, please acknowledge by checking the box and providing your signature and I understand services will be priced using customary fees.

______________________________ ______________________

Patient *or* Parent/Guardian Signature (if patient is under 18 years old **Date**

SECTION I: HEAD OF HOUSEHOLD (please print in all sections of the document)

Last Name:	First Name:	Middle Initial:	# of Dependents
Street Address:	City:	Zip:	County:
Date of Birth:	Social Security #:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

SECTION II: INCOME (please complete for each adult household member who is employed or has any source of income)

Employed Person	Company Name	Gross Income (before taxes)	Paid How Often (check one)
			☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly
			☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly
			☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly
			☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly

Other Sources of Income

Child Support $	Alimony $	Unemployment $	Disability $
Pension/Retirement $	TANF $	Social Security $	Other $

SECTION III: MEMBERS OF THE HOUSEHOLD (list <u>all</u> individuals in household for whom you are LEGALLY responsible including minors under the age of 18 years old or still enrolled in High School and lives in the household)

Name (First, Middle, Last)	Date of Birth	Age	Name (First, Middle, Last)	Date of Birth	Age
1.			5		
2.			6.		
3.			7.		
4.			8.		

By signing below, I agree that Dr. Kent E. Rogers Clinic may contact each employer listed and/or other agencies to confirm my income. I will provide proof of income for the purpose of calculating my discount, if I qualify. I will be asked to document my income regularly (annually if tax return is provided/monthly if paystubs or insurance is provided), and I agree to inform the clinic if there are any changes to income, household size, or insurance coverage indicated above. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I have provided is complete and correct to the best of my ability.

______________________________ ______________________

Patient *or* Parent/Guardian Signature (if patient is under 18 years old) **Date**