RIVER VALLEY
FAMILY HEALTH CENTERS

Convenient Care Clinic Registration Form

Today's Date: _____

Patient Personal Information			
LAST NAME	**First Name**		**MIDDLE INITIAL**
PREVIOUS NAME (LAST, FIRST)	**LEGAL SEX**	**DATE OF BIRTH** / /	
SOCIAL SECURITY NUMBER - -	**MOTHER'S MAIDEN NAME**	**PREFERRED NAME**	
Contact Information			
ADDRESS	**MAILING ADDRESS**		**ZIP CODE**
CITY	**STATE**	**CELL PHONE NUMBER**	
HOME PHONE: **WORK PHONE:**	OKAY TO LEAVE A MESSAGE W/WHOMEVER ANSWERS THE PHONE YES ☐ NO ☐ IT'S OKAY TO LEAVE A MESSAGE ON MY VOICEMAIL YES ☐ NO ☐		
CONSENT TO TEXT YES ☐ NO ☐	**Primary Care Physician:**		
CONTACT PREFERENCE MOBILE ☐ HOME ☐ WORK ☐ MAIL☐ EMAIL☐ PORTAL ☐			**CONSENT TO CALL** YES ☐ NO ☐
EMAIL ADDRESS			**PATIENT PORTAL** YES ☐ NO ☐
Demographics			
LANGUAGE: ENGLISH ☐ SPANISH ☐ DECLINE TO ANSWER ☐ OTHER☐			
RACE: ALASKA NATIVE ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER RACE ☐ DECLINE TO ANSWER ☐			
ETHNICITY: NOT HISPANIC OR LATINO ☐ MEXICAN ☐ MEXICAN - AMERICAN ☐ CHICANO/A ☐ CENTRAL AMERICAN ☐ CUBAN ☐ DOMINICAN ☐ HISPANIC ☐ LATINO/A ☐ SPANISH ORIGIN ☐ PUERTO RICAN ☐ SOUTH AMERICAN ☐ SPANIARD ☐ DECLINE TO ANSWER ☐			
MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ PARTNER ☐			
SEXUAL ORIENTATION: LESBIAN, GAY OR HOMOSEXUAL ☐ STRAIGHT OR HETEROSEXUAL ☐ BISEXUAL ☐ SOMETHING ELSE, PLEASE DESCRIBE ☐ DON'T KNOW ☐ CHOOSE NOT TO DISCLOSE ☐			
GENDER: MALE ☐ FEMALE ☐ CHOOSE NOT DISCLOSE ☐		**HOMEBOUND:** YES ☐ NO ☐	

Revised February 2025

RIVER VALLEY
FAMILY HEALTH CENTERS

DEMOGRAPHICS CONTINUED

WILL HELP DETERMINE YOUR ELIGIBILITY FOR SLIDING FEE & CICP INSURANCE APPLICANTS

FAMILY SIZE	**INCOME:** $0 –39,999 ☐ $40,000 – 79,999 ☐ $80,000 – 149,999 ☐ $150,000 OR MORE ☐
NUMBER OF DEPENDENTS:	

AGRICULTURAL STATUS: SEASONAL WORKER ☐ MIGRANT WORKER ☐ DEPENDENT OF MIGRANT ☐ DEPENDENT OF SEASONAL ☐ NON-AGRICULTURAL WORKER ☐

1. Have you or a member of your family ever worked as an agricultural laborer, including orchards, greenhouses, nurseries, agriculture, work with animals such as cattle, dairy, sheep, poultry, fish hatcheries, etc.? YES ☐ NO ☐
2. Have you or a member of your family moved in the past two years to another area (established a temporary home) in order to work primary in agriculture? YES ☐ NO ☐
3. Have you or a member of your family worked in past two years primarily in agriculture, without moving away from your home? YES ☐ NO ☐
4. Have you or a member of your family stopped traveling to work in agriculture because of disability or old age? YES ☐ NO ☐

HOMELESS STATUS: YES ☐ NO ☐ DECLINE TO ANSWER ☐
If homeless: Doubling up ☐ Homeless Shelter ☐ Street ☐ Transitional ☐ Unknown ☐ OTHER (PLEASE DESCRIBE) ☐

SCHOOL-BASED HEALTH CENTER PATIENT: YES ☐ NO ☐ DECLINE TO ANSWER ☐

VETERAN STATUS: YES ☐ NO ☐ DECLINE TO ANSWER ☐

PUBLIC HOUSING PATIENT: YES ☐ NO ☐ DECLINE TO ANSWER ☐

HOW DID YOU HEAR ABOUT US? ADVERTISING ☐ PRIMARY CARE PHYSICIAN ☐ HOSPITAL ☐ SPECIALIST PHYSICIAN ☐ WORD OF MOUTH ☐ PATIENT IN PRACTICE ☐ INSURANCE COMPANY ☐ FAMILYMEMBER SOCIAL MEDIA ☐ OTHER (PLEASE DESCRIBE) ☐

EMERGENCY CONTACT

FULL NAME	HOME PHONE	MOBILE PHONE

RELATIONSHIP: SPOUSE ☐ PARENT ☐ CHILD ☐ SIBLING ☐ FRIEND ☐ COUSIN ☐ GUARDIAN ☐ OTHER (PLEASE DESCRIBE) ☐

PARENT/GUARDIAN IF UNDER 18

LAST NAME	FIRST NAME	MIDDLE INITIAL

GUARANTOR (PAYER OR RESPONSIBLE PARTY FOR PAYMENT)

LAST NAME	First Name	MIDDLE INITIAL

DATE OF BIRTH / /	ADDRESS	ZIP CODE

CITY	STATE	SOCIAL SECURITY NUMBER - -

GUARANTOR (PAYER OR RESPONSIBLE PARTY FOR PAYMENT) CONTINUED			
EMAIL	**PHONE NUMBER**		**EMPLOYER**
INSURANCE			
TYPE OF INSURANCE SLIDING FEE ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE INSURANCE ☐ CICP ☐ CHP+☐ CORE ☐ VICTIM'S COMP ☐ VOCATIONAL REHAB ☐ FEDERAL PROBATION ☐ EAP ☐ OTHER (PLEASE DESCRIBE) ☐ IF YOU DO NOT HAVE HEALTH INSURANCE, WOULD YOU LIKE TO RECEIVE INFORMATION ON OTHER PROGRAMS YES☐ NO☐			
INSURANCE COMPANY **POLICY/MEMBER NUMBER**			
PATIENT'S PREFERRED PHARMACY & CITY			

CONSENT FOR TREATMENT

I give my permission for River Valley Family Health Centers to provide medical, dental, and/or behavioral health services to me or my child named on page four (4). I verify that all the information provided is truthful. I attest the number of dependents is correct on page five (5) (my reported household size). I attest that my income listed is correct. I understand that payment must be made at the time of service.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the services provided to me by River Valley Family Health Centers. Even if I have insurance coverage, I may owe money in addition to that which was paid by my insurance.

I authorize and direct any holder of medical information or documentation about me or my child to release such information to the River Valley Family Health Centers and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by River Valley Family Health Centers. I authorize payment of third- party benefits directly to the River Valley Family Health Centers for services rendered for myself and/or my dependents.

Signature of Patient _____ Date _____

Signature of Guardian (if patient under 18) _____ Date _____