Est. 1993
TREASURE COAST
COMMUNITY HEALTH

Patient Registration

Social Security: _____ **Birth Date:** _____ **Birth Sex:** _____ **Preferred Name/Pronoun:** _____

First Name: _____ **Mid. Initial:** _____ **Last Name:** _____

Home Address: _____ **Apt/Suite #** _____

City: _____ **State:** _____ **Zip Code:** _____

Email (13 and older): _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Preferred Phone:
☐ Home ☐ Work ☐ Cell

Please communicate by:
☐ Phone ☐ E-mail ☐ Text

Gender Identity: ☐ Male ☐ Female ☐ Declined ☐ Other

☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female

☐ Genderqueer; Neither Exclusively Male nor Female

Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Unknown ☐ Decline

Race: ☐ White ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

☐ Asian Indian ☐ Hawaiian, Native ☐ Samoan ☐ Other Pacific Islander ☐ Guamanian/Chamorro

☐ Black/African American ☐ More than 1 race ☐ American Indian/Alaska Native ☐ Unreported/Refuse

Ethnicity: ☐ Not Hispanic, Latino/a or Spanish Origin ☐ Unreported/Refused ☐ Cuban ☐ Puerto Rican

☐ Mexican, Mexican American, Chicano/a ☐ Other Hispanic, Latino/a or Spanish Origin: _____

Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ Sign Language ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Employment Status: ☐ Unemployed ☐ Employed ☐ Self-Employed ☐ Disabled ☐ Retired ☐ FT Student ☐ PT Student

How did you hear about us: ☐ Another Healthcare Facility ☐ Community Event ☐ Friend ☐ TCCH Employee ☐ Relative

☐ Google ☐ TCCH Website ☐ Twitter ☐ Facebook ☐ Instagram ☐ LinkedIn ☐ YouTube ☐ Other ☐ TV ☐ Radio

As a Federally Qualified Health Center, Treasure Coast Community Health is required to ask the following questions for all members in the household. **This information is required for all patients including children**

Income Period: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-Monthly ☐ Quarterly ☐ Annual ☐ Refused

Ex: Taxable wages, tips, self-employment income, unemployment, social security, disability, retirement, investments, workers compensation.

Approximate Household Income (before taxes): _____ **Number of people supported in the household:** _____

Are you Homeless? ☐ Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Doubling up

☐ Permanent Supportive Housing ☐ Street ☐ Unknown ☐ Refused ☐ Other

Do you live in Section 8 Public Housing? ☐ Yes ☐ No **Disabled:** ☐ Yes ☐ No

Worker Status: ☐ Refused ☐ Not Migrant/Seasonal ☐ Seasonal ☐ Migrant

Veteran: ☐ No ☐ Refused ☐ Yes **Military Discharge:** ☐ No ☐ Refused ☐ Yes **Discharge Date:** _____

Refugee Status: ☐ No ☐ Yes If yes specify, **Country of Origin:** _____

Patient Registration
(Continued)

Insurance Information

Are you covered by insurance? ☐No ☐Yes **If yes, please indicate primary insurance:** _____

Subscriber's name: _____ **Birth Date:** _____ **Relationship to subscriber:** _____

Member ID: _____ **Group Number:** _____

Emergency Contact

Name: _____ **Phone Number:** _____ **Relationship:** _____

Pharmacy

TCCH Patients receive the lowest medication prices in the county. If you want access to free and reduced medications, select one of the TCCH pharmacies as your primary pharmacy.

☐Gifford ☐Olso ☐Fellsmere

If you prefer a different pharmacy please provider information on that pharmacy below.

Preferred Pharmacy: _____ **City:** _____ **Phone Number:** _____

Parent/Legal Guardian Information
(Complete if patient is a minor or adult with legal guardian)

Parent's Name: _____ **Phone Number:** _____

Date of Birth: _____ **Email:** _____

Parent's Name: _____ **Phone Number:** _____

Date of Birth: _____ **Email:** _____

Legal Guardian: _____ **Phone Number:** _____

Date of Birth: _____ **Relationship:** _____

The above information is true to the best of my knowledge. I understand it is my responsibility to inform Treasure Coast Community Health in writing of any changes to the above information.

Print Name: _____ Signature: _____

Relationship: _____ Date: _____

Please return this document to the front reception staff

TREATMENT/PAYMENT AUTHORIZATION FOR TREASURE COAST COMMUNITY HEALTH CENTERS, INC (TCCH)

**Please initial next to each line to show that you have read and consent to each statement

1. _____ I give consent and request TCCH to provide me and/or my family with health care**. I acknowledge my responsibility to pay for that care according to the fees established. I have informed TCCH of all insurance coverage and have provided copy of all insurance cards. I understand that I am responsible for all charges and fees for my care, except any that are covered by insurance accepted by TCCH. I understand that payment, including co-insurance, co-pays and self-pay/sliding fee payments, is due at the time of service.

2. _____ **HEALTH CARE RELEASE–**I give consent for release of routine medical record information for the purposes of reimbursement, arranging referrals or other health care. I also allow TCCH to release immunizations records to any school or day care.

3. _____ I give permission for my Protected Health Information (PHI) to be disclosed for the purpose of coordinating health care needs, communicating results, and care decisions to the friends and/or family members listed below (***Initial if applicable***)

Name	Relationship	Contact Number

4. _____ I give permission for my Protected Health Information (PHI) to be captured by a virtual or live Medical Scribe for the purpose of coordinating health care needs, communicating results, and care decisions. This Information may be recorded for quality-control purposes and accurate data entry into your permanent medical record. Any records would be temporary and deleted after entry into the permanent medical record. All information transcribed will be reviewed and verified by your Healthcare Provider.

5. _____ **CARE COORDINATION –** I give consent for coordination of my health care with home and community-based providers of clinical services to also include the chronic care management program.

6. _____ **ACCESS –** I give my consent to access my history from other places (e.g. Pharmacies, Lab Vendors, Accountable Care Organizations), electronically for the purpose of my health care.

7. _____ **PATIENT PORTAL –** I have the opportunity to gain 24 hour access to the Patient Portal. I will keep my sign-on and password safe and access only the accounts I have the right to look at.

8. _____ **TEXT/EMAIL/VOICE –** I give my consent to receive appointment reminders and other healthcare communications/information from TCCH

9. _____ I hereby grant permission to TCCH to use photographs of me or my child taken on _____ at TCCH for identity purposes **ONLY**."

10. _____ **I HAVE BEEN OFFERED AND/OR RECEIVED THE NOTICE OF PRIVACY PRACTICE**

THIS CONSENT WILL STAY IN EFFECT FOR TWELVE (12) MONTHS FROM THE DATE SIGNED.

You have the right to amend or revoke this consent at any time.

Signature of: _____

(Circle One) Patient Parent Guardian Date

TCCH Staff Member: _____ Date: _____

**Health Care – Medical, Dental and/or Behavioral Health