Rockbridge Area Health Center

25 Northridge Lane
Lexington, VA 24450
Phone: 540-464-8700
Fax: 540-464-1362
www.rockahc.org

PATIENT REGISTRATION FORM

I am interested in the following services (check all that apply) ❒ Medical ❒ Dental ❒ Behavioral Health

Patient Information

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Mailing Address

City | State | Zip Code

Physical Address (if different than mailing)

Home Phone | Cell Phone | Work Phone

Gender ❒ Male ❒ Female | Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Email address

How did you hear about us (please check all that apply) ❒ Newspaper ❒ Family/friend ❒ TV ❒ Radio ❒ Facebook ❒ Hospital ❒ Signage on road ❒ Internet search ❒ Insurance company ❒ Other (please specify):

Financial Responsibility of Patient

❒ Self (Skip to next section if checked here) ❒ Parent ❒ Legal Custodian ❒ Guardian/Power of Attorney

Last Name | First Name

Address ❒ Same as above | City | State | Zip Code

Date of Birth | Social Security Number | Home Phone

Employment Information

Are you employed? | Name of Employer
❒ Full-time ❒ Part-time ❒ Retired ❒ Not Employed

Employer Address | City | State | Zip Code

Are you a student?
❒ Full-time ❒ Part-time ❒ Not a Student

Emergency Contact #1

Last Name | First Name

Mailing Address

City | State | Zip Code

Home Phone | Cell Phone | Relationship to Patient

Emergency Contact #2

Last Name | First Name

Mailing Address

City | State | Zip Code

Home Phone | Cell Phone | Relationship to Patient

Pharmacy

Preferred Pharmacy: If left blank, all prescriptions will go to our partner pharmacy, Lexington Prescription Center.

Provider and Insurance Information

If not RAHC, who is your medical primary care physician?

If not RAHC, who is your dental provider?

List other health care professionals involved in your care:

Primary Medical Insurance Company:

Plan ID Number	Plan Group Number
Name of Policy Holder	
Policy Holder's Date of Birth	Policy Holder's Social Security Number

Secondary Medical Insurance Company:

Plan ID Number	Plan Group Number
Name of Policy Holder	
Policy Holder's Date of Birth	Policy Holder's Social Security Number

Primary Dental Insurance Company:

Plan ID Number	Plan Group Number
Name of Policy Holder	
Policy Holder's Date of Birth	Policy Holder's Social Security Number

Do you have an advance directive ❒ Yes ❒ No

If yes, your clinical team would like to have a copy on file. We have sample advance directives if you don't have one.

Additional Patient Information

We collect information on our patients to help us know more about the community we serve and to improve our services. We report this information without identifying patients personally. For example, we report that we serve 100 veterans.

Ethnicity:
- ❒ Hispanic or Latin American
- ❒ Non-Hispanic
- ❒ Unreported/refused to report

Veteran Status: Have you ever been in the Armed Forces of the United States? ❒ Yes ❒ No

Are you active duty military? ❒ Yes ❒ No

Race:
- ❒ Asian
- ❒ White
- ❒ Black or African American
- ❒ Pacific Islander
- ❒ American Indian or Alaskan Native
- ❒ Other race
- ❒ Unreported/refused to report

Preferred Language: ______________________________

Do you require assistance with language interpretation?

❒ Yes ❒ No

Would you like assistance with reading/completing forms?

❒ Yes ❒ No

Sexual Orientation:

❒ Lesbian or Gay ❒ Straight ❒ Bisexual ❒ Something else ❒ Don't know ❒ Choose Not to Disclose

Gender Identity :

❒ Male ❒ Female ❒ Transgender Male (Female to Male) ❒ Transgender Female (Male to Female)
❒ Other ❒ Choose Not to Disclose

Residence: Are you a seasonal resident? ❒ Yes ❒ No
Are you a migrant worker? ❒ Yes ❒ No

Do you live in public housing? ❒ Yes ❒ No
Are you homeless? ❒ Yes ❒ No
Are you living in a multi-family home? ❒ Yes ❒ No

How many people are living in your home, including yourself? __________

What is the estimated total annual household income, including government assistance and disability?

❒ Under $11,000 ❒ $15,001- $20,000 ❒ $25,001- $35,000 ❒ $45,001- $55,000
❒ $11,001- $15,000 ❒ $20,001- $25,000 ❒ $35,001- $45,000 ❒ Over $55,000

Privacy Information

Government HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations require permission from the patient in order for any healthcare professional to speak with family, friends or caregivers regarding your protected health information, except in cases of emergency. RAHC is serious about the responsibility of keeping your medical and account information private and confidential. The RAHC's full Notice of Privacy Practices can be viewed online at www.rockahc.org or by requesting a copy at the Front Office.

In order for us to share any of your information, we must have written permission. We have your permission to talk to the following people about **general medical conditions, lab results, test results, treatment results, or appointment information**:

Name	Relationship	Phone
Name	Relationship	Phone

We have your permission to talk to the following people about **account balance and financial information**:

Name	Relationship	Phone
Name	Relationship	Phone

If we are unable to contact you and you have voicemail, do we have your permission to leave a message? ❒ Yes ❒ No

We utilize an automated system for appointment reminders. If you provided a cell phone number, would you prefer your reminder as a: ❒ Phone call ❒ Text message

Patients with email addresses listed on this registration form will automatically be registered with our patient portal which can be accessed by visiting our website www.rockahc.org. Our patient portal is a way to provide patients with easy access to our services. You can request refills, review your lab results, display/print visit summaries, patient education and immunization records, as well as make payments.

Signature

I understand that by signing this document, I attest to the accuracy of the information provided. I also understand that if the information changes, I will contact RAHC.

Patient Signature	Date
Parent/Guardian Signature	Date