



Please call (540) 464-8700, option 1, or ask a Patient Access Representative for help with filling out forms.

I am interested in the following services: Medical Dental Behavioral Health Family Planning

Patient's Full Legal Name			
Last Name	First Name	Middle Name	
Date of Birth	Social Security Number		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Mailing Address			
City	State	Zip Code	
Physical Address (if different than mailing)			
Preferred Phone	Secondary Phone	Work Phone	
If we are unable to contact you and you have voicemail, do we have your permission to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How do you prefer your appointment reminder? <input type="checkbox"/> Phone call <input type="checkbox"/> Text message <input type="checkbox"/> Email address: _____			
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 . You can request medication refills, view lab results and more.			
<i>For minors:</i>			
Is there a custody order on file? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a current custody order. Note: a parent or legal guardian must be present at the first visit.			
Employment Information			
Are you employed? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	Name of Employer		
Employer Address	City	State	Zip Code
Are you a student? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a Student			
Financial Responsibility (For minor patients, it is the parent/legal guardian completing this form.)			
<input type="checkbox"/> Self (Skip to next section if checked here) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Custodian <input type="checkbox"/> Guardian/Power of Attorney			
Last Name	First Name		
Date of Birth	Social Security Number	Home Phone	
Address <input type="checkbox"/> Same as above	City	State	Zip Code
What is the estimated total annual household income before taxes, including wages and disability? <input type="checkbox"/> Under \$11,000 <input type="checkbox"/> \$15,001- \$20,000 <input type="checkbox"/> \$25,001- \$35,000 <input type="checkbox"/> \$45,001- \$55,000 <input type="checkbox"/> \$11,001- \$15,000 <input type="checkbox"/> \$20,001- \$25,000 <input type="checkbox"/> \$35,001- \$45,000 <input type="checkbox"/> Over \$55,000			
How many people are living in your home, including yourself? _____			

RAHC offers additional savings based on household size and income to uninsured and insured patients. If the income is under this amount per year before anything is taken out, please complete the **Application for the Sliding Fee Discount**.

1 person= \$24,280 2 people= \$32,920 3 people= \$41,560 4 people= \$50,200 5 people= \$58,840 6 people= \$67,480

**Limits are higher for Family Planning Services*

Pharmacy

Name of Preferred Pharmacy: _____

If left blank, all prescriptions will go to Lexington Prescription Center, where patients receive the biggest discount.

Provider Information

Are you transferring medical care to RAHC? Yes No If yes, from which practice?

Are you transferring dental care to RAHC? Yes No If yes, from which practice?

List other health care professionals involved in your care:

Do you have an advanced directive Yes No

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

Medical Insurance

Do you have medical insurance Yes No If yes, insurance company name: _____

Plan ID Number _____ Plan Group Number _____

Policy Holder Name _____ Date of Birth _____ Social Security Number _____

Policy Holder Address _____ Phone Number _____

Do you have secondary health insurance Yes No If yes, insurance company name: _____

Plan ID Number _____ Plan Group Number _____

Policy Holder Name _____ Date of Birth _____ Social Security Number _____

Policy Holder Address _____ Phone Number _____

Dental Insurance

Do you have dental insurance Yes No If yes, insurance company name: _____

Plan ID Number _____ Plan Group Number _____

Policy Holder Name _____ Date of Birth _____ Social Security Number _____

Policy Holder Address _____ Phone Number _____

Dental Benefits Phone Number on Card _____

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.*

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

Are you active duty military? Yes No

Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other race <input type="checkbox"/> Unreported/refused to report	
Ethnicity: <input type="checkbox"/> Hispanic or Latin American <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unreported/refused to report	
Preferred Language: _____ Do you require assistance with language interpretation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexual Orientation: <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose Not to Disclose	
Gender Identity : <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (Female to Male) <input type="checkbox"/> Transgender Female (Male to Female) <input type="checkbox"/> Other <input type="checkbox"/> Choose Not to Disclose	
Residence: Are you a seasonal resident? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you live in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you living in a multi-family home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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 scheduling, medical, account/financial information.	
Name of Emergency Contact #1	Permission to discuss <input type="checkbox"/> Medical <input type="checkbox"/> Financial
Home or Cell Phone Number	Relationship to Patient
Name of Emergency Contact #2	Permission to discuss <input type="checkbox"/> Medical <input type="checkbox"/> Financial
Home or Cell Phone Number	Relationship to Patient
Name of Emergency Contact #3	Permission to discuss <input type="checkbox"/> Medical <input type="checkbox"/> Financial
Home or Cell Phone Number	Relationship to Patient
Name of Emergency Contact #4	Permission to discuss <input type="checkbox"/> Medical <input type="checkbox"/> Financial
Home or Cell Phone Number	Relationship to Patient
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. (For minor patients, parent/legal guardian completing this form sign below.)	
Signature	Print Name
Relationship to patient	Date
I have received a copy of the Patient Rights and Responsibilities. Initial here: _____	