DAILY PLANET HEALTH SERVICES REGISTRATION FORM

Date: ___________________________

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
Preferred Name:	**Date of Birth:**	**SSN**:
Address:	**Email**:	
City:	**State:**	**Zip:**

Primary Phone #: *Type:* □ Cell □ Home □ Work	**Secondary Phone #:** *Type:* □ Cell □ Home □ Work

How do you like to be contacted? □ Phone Call (Cell) □ Phone Call (Home) □ Text □ Email □ Patient Portal

Birth Sex: □ Male □ Female | **Sexual Orientation**: □ Straight □ Lesbian or Gay □ Bisexual □ Other □ Choose Not To Disclose

Gender Identity: □ Male □ Female □ Transgender - Male to Female □ Transgender - Female to Male □ Other

Marital status: □ Single □ Married □ Partner □ Divorced □ Legally Separated □ Widow

Patient Employment Type: □ Full-time □ Part-time □ Self Employed □ Disabled □ Retired □ Unemployed □ Dependent

Patient Employer Name: | **Are you a student?** □ Yes □ No

EMERGENCY CONTACT

Name:	**Relationship**:
Phone #:	**Address:**

ADDITIONAL INFORMATION

Race(s) - Check All that Apply:
□ Black/African American □ Caucasian □ Asian □ American Indian/Alaska Native □ Native Hawaiian □ Other Pacific Islander

Ethnicity: □ Hispanic □ Non-Hispanic | **Are you a US Veteran?** □ Yes □ No

Primary Language: □ English □ Spanish □ Other ____

What is your current living situation?
□ Rent/Own home (self or family) □ Live temporarily with family or friends □ Emergency shelter
□ On the street (outside, abandoned buildings, encampment, car) □ Transitional Housing
□ Other (please specify): ____

Have you worked with an agency to obtain housing in the past year? □ No □ Yes If yes, name of provider ______________

Are you a migrant worker? □ Yes □ No (Move place to place for work)	**Are you a seasonal worker?** □ Yes □ No (Temporary & Part Time)

What service(s) you are seeking? □ Medical Care □ Dental Services □ Vision Care □ Mental Health □ Substance Use

Were you referred by someone? □ No □ Yes If yes, who referred you? ____

Do you have a primary care provider? □ No □ Yes If yes, name of provider _____________________________________

We have team-based care so providers can better coordinate your care. You can select your medical provider.
Choose one of the following:
□ Earliest Available Appointment (either location)

□ West Grace Health Center (circle name): Mercy Bradshaw / Cara Campbell / Renee Hammel / Stephen Popovich / Molly Seay

□ Southside Health Center (circle name): Kathleen DiPasquale / Helen Tanner / Renee Hammel / Usha Sundaram

INSURANCE INFORMATION

Do you have health insurance? ◻ No ◻ Yes	**Relationship to policy holder**: ◻ Self ◻ Spouse ◻ Child ◻ Other
***Select all that apply and provide a copy of your card*.** ◻ Medicaid ◻ Medicare ◻ VA Healthcare ◻ VCC ◻ Medicaid MCO ◻ Private ◻ Other ◻ None	

Daily Planet Health Services (DPHS) offers a Sliding Fee Discount Schedule for persons up to 200% of the poverty level. This schedule is based on the current year's Federal Poverty Income Guidelines. If you wish to apply for discounted fees, proof of income is required to determine level of eligibility. Please see the Fee Payment and Proof of Income Notice form and Sliding Fee Eligibility Documentation Form, located in your registration packet, for detailed information. If you do not enroll in the Sliding Fee Discount program, you are responsible for the full amount of your visit.

HOUSEHOLD INFORMATION

Name	Relationship	DOB	Age

Total Number of people in household (including yourself) ________

HOUSEHOLD INCOME - Include all sources, including but not limited to, employment, unemployment benefits, SSI/SSDI, Veterans Benefits, Pension, Retirement, TANF, Child Support, Alimony

Name of Person Receiving Income	Source	Amount	Frequency

Total Household Income: $ _____________ ◻ Annually ◻ Monthly ◻ Weekly ◻ Bi-weekly ◻ Bi-monthly

If no income is received, how do you provide food and shelter for yourself and your family? _________________________________

Please note: Daily Planet Behavioral Health Clinic ***<u>does not provide one-time only</u>*** *mental health evaluations for court, disability benefits, or other purposes. If you are in need of this service only, we can refer you to another agency that can do it for you.*
*****_______***<u>PLEASE INITIAL HERE</u>******

I hereby certify that all information provided on this form is true. I understand that this application will be ***reviewed each visit and that proof of income is required annually***, **and as income changes**. I further understand that, if applicable, I must provide proof of homelessness initially, monthly and as my circumstances change. I understand that if I give false information, withhold information, or fail to report my income, that I could be prosecuted for perjury, larceny, and/or fraud.

____ ___________________________ ____________________

Signature **Printed Name** **Date**

____ ___________________________ ____________________

Staff Signature **Printed Name** **Date**