PATIENT REGISTRATION FORM

This application expires twelve (12) months from the date signed and must be resubmitted annually.

Patient Name: ____

Date of Birth: ________________________ **Sex:** ☐Male ☐Female

Race: ☐White ☐Black/African American ☐Asian **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic/Latino

Address: ____

Preferred Phone: ______________________________ **Alternate Phone:** ___________________________

If patient is a minor who is the legal guardian for child? ______________________________

Relationship: ______________________________

Emergency Contact Name: ______________________________ **Relationship:** ___________________

Phone: ______________________________

PATIENT'S HEALTH INSURANCE INFORMATION

Are you part of a state or federally funded Program? ☐No ☐Yes: ☐ Medicaid/Healthy Indiana Plan ☐ Medicare

Do you have Shalom or Eskenazi Advantage (includes Pecar, Westside Clinic, Raphael, St.Vincent) ☐No ☐Yes

Do you have private health insurance? ☐ No
☐Yes - **Please complete information below and have insurance cards ready to photocopy.**

PRIMARY INSURANCE COMPANY____

Name of Insured ____

Address ____

City, State, Zip ____

Phone Number ______________________________ Birth Date______________________________

Insured's relationship to patient? ____

PATIENT'S EMPLOYMENT AND FINANCIAL INFORMATION

Employed: ☐ Full time ☐ Part-time ☐Temp ☐Self-Employed ☐Unemployed ☐Disabled ☐ Retired

Military Satus: ☐Active ☐Veteran ☐N/A

Supported by: ☐ Self ☐ Combined income: Self & Spouse ☐ Spouse Only ☐Child Only

☐Other/Name ______________________________

Account# _______________ (Office Use Only)

Total Family Yearly Income

☐$0-$12,000
☐$12,001-$15,000
☐$15,001-$18,000
☐$18,001-$21,000
☐$21,001-$24,000
☐more than $24,000
☐Decline to provide income

Would you like to apply for Sliding Fee Scale? ☐ Yes ☐ No Signature___________________________________

List all family members currently living in household, ***including Patient.***

Name	Social Security Number	Date of Birth: Month/Day/Year	Relation to applicant
1. Patient:			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

AUTHORIZATION: I hereby authorize any bank or financial institution, government agency or department, hospital, physician, corporation or individual to furnish any information concerning this application to any authorized agent of Shalom Health Care Center, Inc. Under penalty of perjury, I affirm the above information is true and correct to the best of my knowledge. I further authorize the Shalom Health Care Center to release any information regarding services rendered by any provider to my health insurance company and, in case of Medicare, to the Centers of Medicare and Medicaid Services and its agents; and allow a photocopy of my signature to be used to file insurance, including Medicare, when applicable. I request that payment, including Medicare authorized benefits, be made on my behalf to Shalom Health Care Center. Regardless of my health insurance benefits, if any, I understand I am financially responsible for the fees for covered services and any costs incurred. I further understand that if my account is turned over to a collection agency, I will be responsible for any interest charges allowed at the current legal rate, collection fees, reasonable attorney fees and court cost.

Signature ____Date_________________________

THANK YOU FOR CHOOSING SHALOM HEALTH CARE CENTER, INC.

Account# ______________ (Office Use Only)