LBU
Los Barrios Unidos Community Clinic

(Patient Label)

Patient Registration Form

FOR OFFICE USE ONLY Date _____ MR # _____ Check if update ☐

Patient Information

Gender Identity:
☐ Female ☐ Male ☐ Transgender Man ☐ Transgender Woman ☐ Other ☐ Chose not to disclose

Last Name _____ First Name _____ Middle Name _____
Address _____ City/State _____ Zip _____
Cell Phone (____) _____ Home Telephone (____) _____
Patient's Date of Birth _____ E-mail _____

Sexual Orientation:
☐ Straight (heterosexual) ☐ Lesbian or Gay (homosexual) ☐ Bisexual ☐ Other ☐ Chose not to disclose

Contact Preference:
☐ Don't call home number ☐ Don't call work number ☐ Don't leave a message ☐ OK to leave a message ☐ Other (please include how you would like to receive messages)_____ ☐ Confidential

Language Preferred: _____

Ethnicity:
☐ Non-Hispanic/Latino ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic ☐ Hispanic Combined ☐ Refused to report

Race:
☐ White ☐ Black ☐ Vietnamese ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ American Indian/ Alaskan Native ☐ More than one race ☐ Choose not to disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Emergency Contact

First and Last Name _____ Relationship to Patient _____
Emergency Contact Phone Number (____) _____ *should not be patient's phone number

Responsible Party Name of Parent /Guardian _____
Relationship to patient _____ Date of Birth _____

Financial Information

Insurance Information Are you currently insured? ☐ YES ☐ NO
Insurance: ☐ MEDICAID ☐ CHIP ☐ MEDICARE ☐ BLUE CROSS/BLUE SHIELD
☐ OTHER _____
ID # _____ Group # _____

Preferred Pharmacy: ☐ LBU Community Clinic (LBU) ☐ Other _____
Name _____ Phone (____) _____
Address or Location _____

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Financial Information

You may be eligible for a discount on your clinic fees. If you would like to be considered for a possible discount, we will need to collect household income information. You will need to provide proof of income such as W2 Forms or check stubs. All of this information is private and confidential. Patients will not be denied services based on their inability to pay.

Family Information

List immediate family members under the age of 18 living in the household including yourself and your spouse

1. _____ _____ _____
   Name | Date of Birth | Insurance Carrier
   _____
   Relationship to Patient
2. _____ _____ _____
   Name | Date of Birth | Insurance Carrier
   _____
   Relationship to Patient
3. _____ _____ _____
   Name | Date of Birth | Insurance Carrier
   _____
   Relationship to Patient
4. _____ _____ _____
   Name | Date of Birth | Insurance Carrier
   _____
   Relationship to Patient
5. _____ _____ _____
   Name | Date of Birth | Insurance Carrier
   _____
   Relationship to Patient

Financial Information

1. _____ $ _____
   Name of family member | Gross Income
   Check one ☐ Paid weekly x52 ☐ Paid every 2 weeks x26 ☐ Paid monthly x12 ☐ Twice monthly x24
2. _____ $ _____
   Name of family member | Gross Income
   Check one ☐ Paid weekly x52 ☐ Paid every 2 weeks x26 ☐ Paid monthly x12 ☐ Twice monthly x24
3. _____ $ _____
   Name of family member | Gross Income
   Check one ☐ Paid weekly x52 ☐ Paid every 2 weeks x26 ☐ Paid monthly x12 ☐ Twice monthly x24

Total Gross Annual Income for Household $ _____

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Financial Information

Signatures

☐ Patient Rights and Responsibilities: I understand my rights and responsibilities as described and given to me in the Patients' Rights and Responsibilities brochure and the Privacy Form.

☐ Consent for Electronic Sharing and Health Information Exchange: I authorize LBU to use Patient's Medical Information for Patient's treatment and related services. Unless I object, I authorize LBU to release and send Patient's Medical Information to Patient's non-LBU healthcare providers electronically and / or through a Health Information Exchange, an organization that provides services to enable the electronic sharing of health-related information. Medical Information disclosed pursuant to this authorization may be used for treatment, payment and operational purposes

☐ I certify that the above information is true and correct. I understand that I am responsible for payment of medical and dental services not covered by insurance.

Patient/Parent/Legal Guardian

Business Office Staff

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Consent to Treatment

Name: _____

Chart #: _____

Date of Birth: _____

I, the undersigned, hereby give my consent to LBU Community Clinic (LBU) and its medical staff, including physicians, physician assistants, advance practice nurses, social workers, and dentists, to examine in person and/or by telehealth, administer tests and treatments, prescribe therapy, or perform other procedures that are deemed necessary and advisable for the above mentioned patient in connection with any illness or condition for which the above patient has been brought or may hereafter come to LBU.

I understand that this consent is valid and remains in effect as long as the above person is a patient of LBU. I certify that I have read the above and understand its contents.

Signature: _____ Date: _____

☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____

Witness: _____ Date: _____

CONSENT TO TREATMENT OF MINOR BY NON-PARENT: In accordance with Texas Family Code, I am the grandparent of the child, or the adult brother or sister, or the adult aunt or uncle, or an adult who has care and control of the minor and has written authorization to consent from the person having the power to consent as provided by law and have full authority to consent to the medical treatment of the above mentioned minor.

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Initial Learning Assessment

Name _____ Date _____ Date of Birth _____

To be completed by the patient or legal guardian

If unable to complete, request assistance from LBU personnel

Name of Patient or Legal Guardian _____

Factors that Affect Learning

Do you speak English? ☐ Yes ☐ No

If the answer is no, what language do you speak? _____

Do you wear glasses or contacts? ☐ Yes ☐ No

Do you wear a hearing aid? ☐ Yes ☐ No

Personal Details

Do you have any cultural or religious practice/beliefs that may affect your care of treatment?

☐ Yes ☐ No If Yes, explain _____

Education Level (circle highest completed level)

0 1 2 3 4 5 6 7 8 9 10 Some College College Degree

Learning Preferences

How do you like to learn new things (Check all that apply)?

☐ Reading

☐ Discussion

☐ Pictures/Diagrams

☐ Hands on Demonstration

_____ _____

Patient Signature Date

_____ _____

LBU Staff Signature Date

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Protected Health Information

In order to protect your privacy under HIPAA, this form allows our patients to provide written consent to our office in order to release medical information to persons of your choosing. This consent will also be used for telephone messages. The information herein will become a part of your medical record until changed by you in writing.

Patient Information

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________

Phone: (_____) ______________ E-mail: ______________________

Authorized Release of Patient Information

List of names of family or friends we can discuss your medical information with:

Name ______________________

Relation ______________________

Phone number (_____) ______________

☐ ALL information containing my Health Information
-OR-
☐ SPECIFIED portions of my Health Information
- ☐ Lab and X-ray Results
- ☐ Medication Refills
- ☐ Medical Advice and Medical Condition

Name ______________________

Relation ______________________

Phone number (_____) ______________

☐ ALL information containing my Health Information
-OR-
☐ SPECIFIED portions of my Health Information
- ☐ Lab and X-ray Results
- ☐ Medication Refills
- ☐ Medical Advice and Medical Condition

Name ______________________

Relation ______________________

Phone number (_____) ______________

☐ ALL information containing my Health Information
-OR-
☐ SPECIFIED portions of my Health Information
- ☐ Lab and X-ray Results
- ☐ Medication Refills
- ☐ Medical Advice and Medical Condition

By signing below, I affirm that the information above is correct and current.

______________________ ______________

Patient Signature Date

____

Printed Name