HOPE CLINIC OF ROSS COUNTY

NEW PATIENT REGISTRATION

Patient Number	PLACE LABEL HERE

TODAY'S DATE: _____ REASON FOR VISIT: _____

IDENTIFYING INFORMATION: [PLEASE PRINT]
Legal Name (First and Last)_____
Age: _____ Date of Birth: _____

PREFERRED CONTACT INFORMATION:
Phone: _____ Email: _____
Other: _____
ADDRESS: _____ City: _____
County:_____ State:_____ Zip: _____

DEMOGRAPHICS:
Ethnicity : □ Non-Hispanic □ Hispanic
Race : □ African-American □ Caucasian □Asian □ Am Indian □ Other_____
Preferred Language: □ English □ Spanish □ Other _____
Male _____ Female_____ Married_____ Widowed _____ Single_____ Divorced_____

I am interested in receiving more information on the following:
Prayer Support ___ Dental ___ Pharmacy___ Vision Services____ Community Resources ___

Are you eligible to receive treatment under any governmental healthcare program such as Medicaid, Medicare, Disability, Medical Assistance, etc? Yes_____ No _____
Do you have private health insurance of any kind?
Yes _____ No _____
Do you make more money than the income range listed here based on your family size? Yes ____ No ____

- ❑ If you answered yes to any of the questions, please see someone at the front desk for referral information.
- ❑ If you truthfully answered NO to ALL questions, you qualify and may continue to sign and complete the remaining forms.

300% Federal Poverty Guidelines for 2023. (For each additional person, add $5,140)

Family Size	Annual Income
1	$43,740
2	59,160
3	74,580
4	90,000
5	105,420
6	120,840

_____
Patient Signature Date