VNA Health Care Registration Form

Pt. ID#: _____ **Primary Provider:** _____

PATIENT INFORMATION

First Name: _____ **Last Name:** _____

Address: _____ **Sex:** _____

City, State, Zip: _____ **Date of Birth:** _____ **Social Security #:** _____

Marital Status: _____

Phone: _____ **Ok to Call:** **Ok to leave message:**

I agree to receive prerecorded messages and or appointment reminders to this number. My plan's voice messaging charges may apply.

Phone: _____ **Ok to Call:** **Ok to leave message:**

I agree to receive prerecorded messages and or appointment reminders to this number. My plan's voice messaging charges may apply.

Consent for Text Messages:_____ I have agreed to receive text messages, including appointment reminders, at this number
(*Your plan's voice and text messaging charges may apply)

E-mail Address:_____ I have agreed to receive information from VNA about the patient portal and special events

Primary Language: _____

Translation Required: **Homeless:** **Public Housing:**

ADDITIONAL INFORMATION

Race: [ ] White [ ]Black/African American [ ]American Indian/Alaskan Nativ [ ]Asian [ ]Native Hawaiian or other Pacific Islander [ ] More than One Race [ ] Decline to Report

Ethnicity: [ ] Hispanic [ ]Non-Hispanic [ ]Declined

U.S. Citizen: [ ] US Citizen [ ] Non-US Citizen [ ] Decline to Report

Family Size/Income

Family Size: **Weekly Income:**

Please present Paycheck stubs to VNA employee

EMERGENCY CONTACT - Name, Relationship, Phone

Does this person know that you are a patient with the VNA?: [] Yes [] No

Name: _____

Phone: _____ **Relationship:** _____

I give VNA permission to speak to the above person about my medical conditions
[ ] Yes [ ] No

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Company: _____

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Company: _____

The parent or guardian has stated that the child qualifies for vaccination through the Federal Vaccines for Children Program because he or she:

(Check Only One box)

☐ Is an American Indian or Alaskan Native ☐ Is enrolled in Medicaid ☐ Does not have insurance

I hereby request and consent to the procedures, test and exams provided by VNA Health Care, or its subcontractors including those related to the family planning, Breast and Cervical Cancer Screening, and Immunizations program. I also agree to follow up on any treatment which may be deemed advisable by the Physicians or Nurse Practitioners of the facility. I understand that I am responsible to provide VNA Health Care correct contact information so I can receive test results of abnormal findings. I have read and understand the notice of Health Information Practices and Consent for Release of Information. I verify that I have been informed of the VNA Health Care Client Bill of Rights and of its locations in the VNA health Center.

Signature: _____ Relationship: _____ Date: _____

VNA Employee Signature: _____