**Matagorda Episcopal Health Outreach Program dba Vibrance Health is a Federally Qualified Health Center (FQHC). To provide the best clinical care for our patients we are required to collect detailed information about you in which a health record will be established and maintained for each patient who receives services at our health center. All information is strictly confidential. Your personal information will not be released without your consent and knowledge.**

## Patient Registration Form

| Last Name | First Name | Preferred Name : ( If Applicable) | | |
|---|---|---|---|---|
| | | | | |
| Social Security Number | Date of Birth | Mailing Address | City | State |
| | | | | |
| Zip Code | County | Sexual Orientation: | Gender | Sex at Birth |
| | | ○ Lesbian, Gay, Homosexual<br>○ Straight or Heterosexual<br>○ Bisexual<br>○ Something else<br>○ Don't know<br>○ Choose not to disclose | ○ Male<br>○ Female<br>○ Transgender Male [F-to-M]<br>○ Transgender Female [M-to-F]<br>○ Other<br>○ Choose not to disclose | ○ M<br>○ F |
| Main Phone Number | Other Phone Number | | | |
| | | | | |
| Email Address: | Family Size | | | |
| | | | | |

Preferred Method of Contact (if needed circle more than one) :

Cell Phone  Text (SMS)  Email  US Mail  Patient Portal

| House Hold Income | Ethnicity: | Race: | Housing Status: |
|---|---|---|---|
| □ Monthly<br>□ Annually<br><br>Amount $_____ | □ Hispanic<br>□ Non-Hispanic | □ Asian<br>□ Native Hawaiian<br>□ Pacific Islander<br>□ Black/ African American<br>□ White<br>□ American Indian<br>□ More than one Race<br>□ Refuse To report | ○ Not Homeless<br>○ Doubling Up<br>○ Homeless Shelter<br>○ Other<br>○ Street<br>○ Unknown<br>○ Transitional |

Patients Choices- Please Read Carefully and select "Yes" or "No" to the following Questionnaire

*We need your permission to allow Vibrance Health to electronically exchange your health information with other health care providers, entities, and yourself. The Exchange is secure and improves the speed, quality, safety and cost of the patient's care and experience. Do we have your permission?* ***Yes*** *or* ***No***

We would like your permission to send you SMS text messages and/or Email for Appointment Confirmation. Do you allow SMS messaging? (please circle one) **Yes** or **No** If Yes, please provide Cell Phone Number

_____

Do you consent to using the Exchange to ensue speed and reliability? *(Please Circle One)* **Yes** or **No**

Do you consent to using the Immunization Registry? *(Please Circle One)* **Yes** or **No**

Do you consent to using our Patient Portal? *(Please Circle One)* **Yes** or **No**

**Please Continue on the Next Page**

**Vibrance Health is a Federally Qualified Health Center (FQHC). To provide the best clinical care for our patients we are required to collect detailed information about you in which a health record will be established and maintained for each patient who receives services at our health center. All information is strictly confidential. Your personal information will not be released without your consent and knowledge.**

| Last Name | Language Best Served In: | Attending School? Grade Completed? | | |
|---|---|---|---|---|
| | | o YES o No K 1 2 3 4 5 6 7 8 9 10 11 12 | | |
| Veteran Status | Are you currently Active Military? | Vibrance Health offers eligibility services. Would you be willing to participate? | Do you have Medicare? #? | Medicaid? #? |
| | | | | |
| Do you have Medical/ Dental insurance? | If YES, is it through your employer? | Agricultural Status: | Marital Status: | |
| | | o Dependent of Migrant<br>o Dependent of Seasonal<br>o Migrant Worker<br>o Not Agricultural Worker<br>o Seasonal Worker | o Single<br>o Married<br>o Divorced<br>o Widowed<br>o Separated<br>o Life Partner<br>o Unknown | |
| Subscribers Name | Subscribers Date of Birth | | | |
| | | | | |
| Subscribers Social Security # | Policy Number: | | | |
| | | | | |

| Secondary Insurance Company Name: | Policy Number: |
|---|---|
| | |

| Secondary Insurance Information: | Person Financially responsible for this account? | Emergency Contact Information:<br>Is it ok to leave a message with your emergency contact? o Yes o No | Spouse Information: |
|---|---|---|---|
| Subscribers Name:<br><br>DOB:<br><br>SS#: | Name:<br><br>Mailing Address:<br><br>Telephone:<br><br>Relationship to Patient | Name:<br><br>Mailing Address:<br><br>Telephone:<br><br>Relationship to Patient: | Name of Spouse:<br><br>Birthday:<br><br>Telephone: |

**If Patient is a Minor**

| How did you hear about Vibrance Health? | Parent or Guardian name/Relationship | Parent or Guardian Social Security # | Parent or Guardian Date of Birth | Sex | Marital Status |
|---|---|---|---|---|---|
| | | | | | |

**Please Continue on the Next Page**

| | Patient Initial |
|---|---|
| **Assignment of Benefits:** I hereby authorize and Direct my insurance carrier(s) plans to issue payment directly to Vibrance Health for medical, pediatrics, OB/GYN, dental, and behavioral health services rendered to myself and/ or my dependents. Regardless of my insurance benefits, I understand that I am responsible for any amount not covered by my insurance benefits. | |
| **Authorization to Release Information:** I hereby authorize Vibrance Health to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment. This order will remain in effect until revoked by me in writing. | |

I solemnly swear (or affirm) that the information included on this form is true and to the best of my knowledge.

| **Signature of Patient or Guardian** | **Date** |
|---|---|
| | |
| **Printed Name** | **If Not Patient List Relationship** |
| | |
| **Witness Signature** | **Date** |
| | |

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED


Matagorda Episcopal Health Outreach Program
dba Vibrance Health

101 Ave F North, Bay City, Texas 77414
Phone (979) 245-2008/Toll Free 1-877-705-2008 Fax: (979) 245-0744