Highlands Health

Patient Registration Form

Highlands Health
315 Locust Street, 2nd Floor
Johnstown, PA
814-534-6242

Patient Demograhic Information

Last Name	First Name	Mid Initial/Name	Maiden or Suffix	Date of Birth

Address

Home Address (No, Street)	City	State	County	Zip Code	Homeless
					☐

Home Phone/Cell Phone	Work Phone	SSN	Gender Identity (circle one)
			Male: ☐ Female ☐ Transgender: ☐ M to F ☐ Choose not to disclose: ☐ F to M ☐

Email Address	Marital Status (Circle one)	Race (circle one)
	Single: ☐ Married: ☐ Widowed: ☐ Separated: ☐ Divorced: ☐ Life Partner: ☐	White: ☐ Black/African American: ☐ American Indian: ☐ Asian: ☐ Pacific Islander: ☐ Unreported/refused: ☐

Ethnicity (circle one)	Country of Birth	Photo ID #	Photo ID Type
Hispanic: ☐ Non-Hispanic: ☐ Latino: ☐ Other: ☐ Unreported/refused: ☐			

USA Citizen	Sexual orientation	Preferred Pharmacy
Yes: ☐ No: ☐	Straight: ☐ lesbian or gay: ☐ Something else: ☐ Do not know: ☐ Choose not to disclose: ☐ Bisexual: ☐	

Emergency Contact Information

Contact Name	Phone number	Relation to Contact

Guardian/ Attorneys name if applicable	How did you hear about us?
	Friend ☐ TV ☐ Radio ☐ paper ☐ social media ☐ doctor ☐ agency ☐ ad ☐ other ☐

Methods of communication:

Are you interested in telehealth?	Device Type	Where can we leave messages regarding your care?
Audio only: ☐ Audio & Video: ☐ No Telehealth: ☐	Phone: ☐ computer: ☐ others: ☐	Cell phone: ☐ work phone: ☐ home phone: ☐ email: ☐ postal: ☐

Can we text you?	Access to your patient portal	Do you have a shared device?	Do you want to be included in our mailing list?
Yes: ☐ No: ☐	Yes: ☐ No: ☐	Yes: ☐ No: ☐	Yes: ☐ No: ☐

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Employment and Household

Employer Name	Employment Status	Length on time on job
Job Title	Type of Income /proof	Employer offers Health insurance. Yes: ☐ No: ☐
Date last worked:	Household Size	Household Annual Income $ 0 - $ 20,000: ☐ $ 20,001 - $ 40,000: ☐ Over $ 40,000: ☐ Household Income: _____
Highest level of education		
Transportation Mode:	Not U.S. Resident: ☐ Veteran: ☐ Migrant or Seasonal Worker: ☐ Female Head of Household: ☐ Disabled: ☐ Person living with HIV or AID's: ☐	Insurance? Yes: ☐ No: ☐
Insurance Type/ Provider		

Yes	No	
☐	☐	In the past year, have you or any family members you live with been unable to get any food?
☐	☐	Are you worried about losing your housing?
☐	☐	Do you feel financially strained to make ends meet?
☐	☐	Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
☐	☐	I have been informed of clinic policies and notice of privacy (HIPAA).
☐	☐	Can we obtain patient's prescribtion history?
☐	☐	I give permission to bill my insurance.
☐	☐	I check here to declare that I currently do not have any income in any source.
☐	☐	I give permission to treat.

Signature (Patient or Guardian if a minor):	Date

Documentation (please attach copy)

- ID
- Insurance
- Income Verification (as required)
- list of medication