Sea Mar
Community Health Centers
Clínica de la Comunidad
Exceptional service. Every person. Every time.

Patient Registration Form

PATIENT INFORMATION

Patient Legal Name: ____
Last First Middle

Patient Preferred Name, if different: ______________________________

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other ____________

Mailing Address: ____
Street City State Zip

Permanent Address: ____
Street City State Zip

Primary Phone: ____________ Type: ________ Secondary Phone: ____________ Type: ________
Cell/Home/Msg Cell/Home/Msg

E-mail Address: ______________ Date of Birth: ____/____/____ Social Security #: ____________
Month/Date/Year

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer (For L&I Only): ____

GENDER IDENTITY

What gender were you assigned at birth on your original birth certificate (check one):

☐ Male
☐ Female
☐ Decline to Answer

Do you think of yourself as (check one):

☐ Male
☐ Female
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Genderqueer, neither exclusively male or female
☐ Additional gender category/(or Other), please specify:
____
☐ Decline to Answer

SEXUAL ORIENTATION

Do you think of yourself as (check one):

☐ Straight or heterosexual
☐ Lesbian, gay or homosexual
☐ Bisexual
☐ Something else
☐ Don't know

EMERGENCY CONTACT INFORMATION

Emergency Contact: ______________________________

Relationship: ______________________________

Date of Birth: ____/____/____
Month/Date/Year

Primary Phone: ____________ Type: ________

Secondary Phone: ____________ Type: ________

GUARANTOR INFORMATION (other than patient)

Guarantor: ______________________________

Relationship: ______________________________

Date of Birth: ____/____/____
Month/Date/Year

Primary Phone: ____________ Type: ________

Secondary Phone: ____________ Type: ________

Is your condition the result of a work injury? ☐ Y ☐ N

Is your condition the result of an auto accident? ☐ Y ☐ N

Date of Injury: ____/____/____

Sea Mar accepts most insurance plans, including Washington Apple Health (Medicaid), Medicare and private or employer-sponsored insurance. If you do you not have insurance, Sea Mar has trained staff who can talk to you about your options. Just ask to speak to a Customer Service Representative.

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: ______________________________

Insurance Company Address: ______________________________
Street City State Zip

Policy Number/Member ID: ____________________ Group Number: ______________

Subscriber Name: ____________________ Subscriber Date of Birth: ____/____/____

Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Co-Pay: $________

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company: ______________________________

Insurance Company Address: ______________________________
Street City State Zip

Policy Number/Member ID: ____________________ Group Number: ______________

Subscriber Name: ____________________ Subscriber Date of Birth: ____/____/____

Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Co-Pay: $________

DENTAL INSURANCE INFORMATION

Dental Insurance Company: ______________________________

Insurance Company Address: ______________________________
Street City State Zip

Policy Number/Member ID: ____________________ Group Number: ______________

Subscriber Name: ____________________ Subscriber Date of Birth: ____/____/____

Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Co-Pay: $________

INCOME INFORMATION

As a community health center, Sea Mar is required to collect income information from all patients. All information is kept confidential. You may qualify for Sea Mar's discounted sliding fee scale. Even if you have insurance, the sliding fee scale can be applied to services and fees not covered by insurance. To apply for the sliding fee scale, please fill out an application and provide the necessary income documentation. Please answer the following questions even if you are not applying for the sliding fee scale.

How many people live in your household? __________ Total Annual Household Income: $ ______________

ADDITIONAL INFORMATION

Primary Medical Provider: ____________________ Primary Dental Provider: ____________________

Do you have a disability? ☐ Y ☐ N

If yes, please choose one of the following: ☐ Developmental Disability ☐ Other Disability ☐ Developmental & Other

BEHAVIORAL HEALTH DEPARTMENT ONLY:

BH Patient Type: ☐ Contract ☐ Self Pay

DSHS Worker: ______________________________

Outside PCP: ______________________________

DEMOGRAPHICS

Please select the race category you most closely identify with:

☐ Asian ☐ Other Pacific Islander ☐ American Indian/Alaska Native ☐ Black/African American
☐ Native Hawaiian ☐ More Than One Race ☐ White ☐ Decline to Answer

Please select the ethnicity category you most closely identify with:

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer

What language are you best served in? ______________________ Do you require interpreter services? ☐ Y ☐ N

SPECIAL POPULATION DESIGNATION *Please answer the following questions to help us best serve you.*

In the past two years, have you or a member of your family worked in agriculture/farming as your/their principle employment including, but not limited to: preparing, irrigating or spraying the fields, nurseries, orchards; planting, picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; planting trees, working with Christmas trees, picking pine needles or Spanish moss; or working on farms that produce chickens, ducks, turkeys, cos, goats, sheet, horses, fish, seafood, etc.?
☐ Y ☐ N

Have you or a member of your family stopped migrating to work in agriculture because of disability or old age?
☐ Y ☐ N

In the past two years, have you or a member of your family established a temporary home in order to work in agriculture?
☐ Y ☐ N

In the past two years, have you or a member of your family worked in agriculture on a seasonal basis without the need to establish a temporary home?
☐ Y ☐ N

Are you currently living with friends or family, in your car, in a shelter, in a hotel or on the street?
If yes, please choose one of the following that best describes your current situation:
☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional Housing ☐ Decline to Answer

Are you a U.S Veteran? ☐ Y ☐ N

Do you live in Public Housing? ☐ Y ☐ N

I certify that the information provided in this form is true and correct to the best of my knowledge:

______________________________ ______________

Patient/Legal Guardian Signature Date

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Community Demographic Form

Updated 12-2021

Please complete the form below. If you have any questions or concerns, please ask your clinician during the appointment.

Patient Name: | Patient ID:

Patient Preferred Name:

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other ______________________

Gender Identity

What sex were you assigned at birth on your original birth certificate (check one)?
☐ Male ☐ Female ☐ Intersex ☐ Decline to Answer

Do you think of yourself as (check one):
☐ Man
☐ Woman
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Gender Queer, neither exclusively male or female
☐ Additional gender category/Other, please specify: ______________________
☐ Decline to Answer

Sexual Orientation

Do you think of yourself as (check one):
☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual
☐ Something else, please specify: ______________ ☐ Don't know ☐ Decline to Answer

Migrant and Seasonal Farmworker Status

In the past two years, have you or a member of your family worked in agriculture/farming, forestry or fisheries as your/their main employment including, but not limited to: Preparing, irrigating or spraying the fields, nurseries, orchards; Planting, picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; Planting trees, working with Christmas trees, picking pine needles or Spanish moss; Working on farms that produce chicken, ducks, turkeys, cows, goats, sheep, horses, fish, seafood, etc.?
☐ Yes ☐ No

In the past two years, have you or a member of your family established a temporary home in order to work in agriculture?
☐ Yes ☐ No

Have you or a member of your family chosen not to establish a temporary home to work in agriculture because of disability or old age? ☐ Yes ☐ No

In the past two years, have you or a member of your family worked in agriculture on a seasonal basis without the need to establish a temporary home?
☐ Yes ☐ No

Housing Status

Are you currently living with friends or family, in your car, in a shelter, in a hotel, or on the street? ☐ Yes ☐ No

If yes, please choose one of the following that best describes your current situation:
☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional Housing ☐ Permanent Supportive Housing ☐ Decline to Answer

Other Demographics

Are you a US Veteran? ☐ Yes ☐ No

Patient Acknowledgement

I have read and understood the above information and declare the information furnished to be to be true and complete to the best of my knowledge.

______________________ ______________
Patient Signature Date

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Sliding Fee Scale Application

To comply with federal regulations and provide you a discount on Sea Mar services, it is necessary for you to fill out this form, answer some personal questions, and provide proof of income. Your answers will be kept on file and in strict confidence.

Patient Name:	DOB:	Patient ID:

Household Size:	Annual Income:	☐ I choose NOT to provide my income.

☐ **I choose NOT to apply for the sliding fee scale.** Please sign and date below.

Signature ______________________ Date ______________

☐ **I choose to apply for the sliding fee scale discount.** The sliding fee scale is available for all patients, regardless of insurance status. If you have insurance, the sliding fee scale discount can be applied to charges not covered by insurance. Please complete the entire form to determine eligible discount.

Household Members

	NAME	BIRTHDATE (MM/DD/YYYY)	HEALTH INSURANCE	RELATIONSHIP	SEA MAR PATIENT?
1					
2					
3					
4					
5					
6					

SOURCE OF INCOME

ANNUAL INCOME	For You	For Spouse	For Children	For Others	Sub Total
Gross Wages, Salaries, Tips					$ 0.00
Social Security & Pensions					$ 0.00
Annuity & Veteran Benefits					$ 0.00
Child Support & Alimony					$ 0.00
Self-Employment & Other					$ 0.00
For "Other," please explain:					
				TOTAL	$0.00

By signing below, I agree to provide Sea Mar Community Health Centers with a proof of income for all persons listed above. Acceptable proof of income includes, but is not limited to, social security statements, paycheck stubs (two most recent), public assistance letter, tax return form, W-2 form, L&I check stub, unemployment check stub.

I understand that I will be asked to reapply for the sliding fee scale at least once a year so Sea Mar can maintain an updated application on file. I certify that the information provided is accurate and complete to the best of my knowledge. I understand that if I knowingly give false information that results in assistance for which I am not eligible, I will be subject to criminal prosecution. I give my consent to release any and all information from whatever source needed to verify the information I have given.

Signature ______________________ Date ______________

OFFICE USE ONLY

Patient is eligible for Sliding Fee Scale: ☐ Yes ☐ No SFS Status (circle one): A B C D E F

POI Requested: ____________ Initial: ________ POI Received: ____________ Initial: ________

Notice of Privacy Practices Acknowledgement

The Notice of Privacy Practices for Protected Health Information describes how Health Records about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns or complaints.

Sea Mar has the responsibility to protect the privacy of your information, provide a Notice of Privacy Practices, and follow information practices that are described in this notice. If you have any questions, please contact Sea Mar's Vice President of Corporate and Legal Affairs at 206.763.5277.

By signing this form, you acknowledge receipt of Sea Mar Community Health Centers' Notice of Privacy Practices and Patient Rights and Responsibilities. Sea Mar encourages you to review these notices carefully.

I acknowledge receipt of Sea Mar Community Health Centers' Notice of Privacy Practices and Patient Rights and Responsibilities.

____
Patient or legally authorized individual signature

____
Date Time

____
Printed name if signed on behalf of the patient

____
Relationship
(parent, legal guardian, personal representative)

Patient Name:
DOB:
Patient ID:
This form will be retained in your medical record.