HOMETOWN FAMILY HEALTH
104 W Commerce St/PO Box 35 Plankinton, SD 57368
605.299.8234 (P) 833.982.0180 (F)

# New Patient Registration

## Current Patient Information – Please Print

Last Name: _____

First Name: _____

Preferred Name: _____

Middle Name: _____

Date of Birth: _____

Address: _____

_____

City: _____ State: _____

Zip: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Social Security #: _____

Sex at Birth: _____Current: _____

Language: _____

Translation Required: _____

Special Communication Needs (Impaired Hearing, Vision Loss etc.): _____

Race: _____

Ethnicity: _____

Marital Status: _____

Employer: _____

Preferred Pharmacy: _____

Preferred Provider:

__ Jennalee Olsen __ Melissa Davis __ Kip Littau

**Online Portal Registration**

- ○ Yes, I give Hometown Family Health authorization to establish an online portal for myself or for my 0-11 aged child
- ○ Email: _____
- ○ No, I do not want a portal account at this time

## Guarantor Information (party responsible for payment on account)

Name: _____

Address: _____

_____

Relationship to Patient: _____

Date of Birth: _____

Phone: _____

Social Security #: _____

## Insurance Information

Insurance Plan Name: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____

Birthdate of Policy Holder: _____

Relationship to Patient: _____

## Emergency Contact Information

***I approve the below contact to have access to my private medical information in its entirety, unless specified in writing below.***

Name: _____

Relationship: _____

Phone: _____

## Additional Contacts

***I approve the below contacts to have access to my private medical information in its entirety, unless specified in writing below.***

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

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# ACKNOWLEDGEMENT, AUTHORIZATION, AND CONSENT

Patient Name: _____ DOB: _____

- I have read the Acknowledgement and Consent Policy for Hometown Family Health (found on our website www.hometownfamilyhealth.org or hard copy available from staff). I request, agree, and consent to the evaluation and treatment of myself and/or child(ren) or dependent as set forth above, including any studies or procedures deemed necessary/appropriate for proper diagnosis or treatment by Hometown Family Health staff. I acknowledge & consent to the use of AI scribe technology to aid these services

Signed: _____

Date: _____

- I have read and understand the HIPAA/Privacy Policy for Hometown Family Health (found on our website www.hometownfamilyhealth.org or hard copy available from staff)

Signed: _____

Date: _____

- I hereby assign my insurance benefits to be paid directly to Hometown Family Health

Signed: _____

Date: _____

- I authorize Hometown Family Health to release medical information required to process my claim with my insurance

Signed: _____

Date: _____

- I have read and understand the Financial Policy for Hometown Family Health (found on our website www.hometownfamilyhealth.org or hard copy available from staff)

Signed: _____

Date: _____

- I authorize Hometown Family Health to obtain/have access to my medication history

Signed: _____

Date: _____

- I authorize my provider's office to contact me by mobile phone via text or call

Signed: _____

Date: _____