HEALTH FIRST™ BLUEGRASS

Place Label Here

Patient Registration Form

Patient Information:	**Last Name:**		**First Name:**
Birthday:	**SSN:**		**Phone:**
Address:			**City, State:**
Email:	**Sex at Birth: M F**		**Zip:**
Language Preference:	**Veteran: Yes No**	**Student: Yes No … If yes, School:**	
Race (circle all that apply):	**American Indian/Alaskan Native Asian African American Native Hawaiian/Pacific Islander Caucasian Unknown Declined to Answer**		
Ethnicity:	**Hispanic/Latino Non-Hispanic/Latino Unknown Declined to Answer**		
Agricultural Work Status:	**Migrant farmworker Seasonal farmworker Year Round farmworker Aged/disabled farmworker Non - Farmworker**		
Guarantor Information:	**Last Name:**		**First Name:**
DOB:	**SSN:**		**Phone:**
Address:			**City, State:**
Relationship to Patient:			**Zip:**
For Pediatric Patients Only			
Parent/Guardian #1 Last Name:		**First Name:**	
Phone Number:	**Relationship to patient:**	**Lives with Patient? Yes No**	
Parent/Guardian #2 Last Name:		**First Name:**	
Phone Number:	**Relationship to patient:**	**Lives with Patient? Yes No**	
Insurance Information:	***If you do not have insurance but would like for someone to help see if you qualify for it, please check this box.*** ☐		
Primary Insurance:			**Copay:**
Member ID :	**Policy/Group Number:**		
Subscriber:	**Subscriber DOB:**	**Subscriber SSN:**	
Secondary Insurance:			**Copay:**
Member ID :	**Policy/Group Number:**		
Subscriber:	**Subscriber DOB:**	**Subscriber SSN:**	
Dental Insurance:	**Member ID:**		**Copay:**
Group Number:	**Policyholder Name:**		**Policyholder DOB:**
Sliding Scale/Self Pay			
Household Family Size:	**Income:**	**Weekly/Bi-Weekly/Monthly**	

Patient (or parent/guardian) Signature _____ **Date:** _____