Patient Number

REGISTRATION INFORMATION

PLACE LABEL HERE

TODAY'S DATE: _____________ **REASON FOR VISIT:** ____

Is this your: First visit to Hope Clinic_______ A return visit to Hope Clinic_________

IDENTIFYING INFORMATION: [PLEASE PRINT]
Legal Name (First and Last)____
Age: ________ Date of Birth: ___________________________

PREFERRED CONACT INFORMATION: □ **No change since last visit**
Phone: _________________________ Email: _____________________________________
Other: ___________________________________
ADDRESS: ____ City: ______________
County:__________. State:_______ Zip: ___________

DEMOGRAPHICS: □ **No change since last visit**
Ethnicity : □ Non-Hispanic □ Hispanic
Race : □ African-American □ Caucasian □Asian □ Am Indian □ Other___________________
Preferred Language: □ English □ Spanish □ Other ______________________________
Occupation: ____________________________
Disabilities: ____

Are you eligible to receive treatment under any governmental healthcare program such as Medicaid, Medicare, Disability, Medical Assistance, etc? Yes________ No ________
Do you have private health insurance of any kind? Yes ______ No ________
Do you make more money than the income range listed here based on your family size? Yes ____ No ____

- ❑ If you answered yes to any of the questions, please see someone at the front desk for referral information.
- ❑ If you truthfully answered NO to ALL questions, you qualify and may continue to sign and complete the remaining forms.

200% Federal Poverty Guidelines for 2022. (For each additional person, add $4,720)

Family Size	Annual Income
1	$27,180
2	36,620
3	46,060
4	55,500
5	64,940
6	74,380

Patient Signature Date