LEGACY MEDICAL CARE

Account Number: _____

Patient Registration

Patient Information

Last Name	Name	MI	Date of Birth

Preferred Name:

Address Apt./Unit	City	State	Zip Code

Sex: ☐ Male ☐ Female | **Email Address** | **Reason Email Not Provided** ☐ Does not have e-mail ☐ Will not disclose ☐ Other

Please check primary phone ☐ **Home Phone** ( ) ☐ **Cell Phone** ( ) ☐ **Work Phone** ( )

Legacy Medical Care Inc. may call, text, or email to remind you of your appointments. ☐ Yes ☐ No

Pronouns: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ Not listed (please specify) _____ ☐ Prefer not to answer

Birth Sex: ☐ Male ☐ Female | **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated

Primary Language: ☐ English ☐ Spanish ☐ Other: _____ | **Do you need an interpreter?** ☐ Yes ☐ No

Race: (Please check all that apply): ☐ Asian Indian ☐ Filipino ☐ Other Asian ☐ Other Pacific Islander ☐ Black/African American ☐ White ☐ Chinese ☐ Japanese ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ American Indian/Alaskan Native ☐ Korean ☐ Vietnamese ☐ Samoan ☐ Other ☐ Chose Not to Disclose Race

Ethnicity: ☐ Mexican ☐ Cuban ☐ Other: _____ ☐ Mexican American ☐ Puerto Rican ☐ Non-Hispanic/Latino ☐ Decline to Specify | **Birth Order Number**

Responsible Party

☐ Self ☐ Another Patient ☐ Guarantor

Name	Last Name	Date of Birth

Address ☐ Same as patient | **Patient Relationship to Insured?**

Pharmacy

Preferred Pharmacy Name	Pharmacy Address

Parent/Guardian Information (If applicable)

Name	Last Name	Date of Birth

Please check primary phone ☐ **Home Phone** ( ) ☐ **Cell Phone** ( ) ☐ **Work Phone** ( )

Address ☐ Same as patient
Email Address

Authorization to contact and give full medical information? ☐ Yes ☐ No

Parent/Guardian Information (If applicable)

Name	Last Name	Date of Birth

Please check primary phone ☐ **Home Phone** ( ) ☐ **Cell Phone** ( ) ☐ **Work Phone** ( )

Address ☐ Same as patient
Email Address

Authorization to contact and give full medical information? ☐ Yes ☐ No

Emergency Contact		
Primary Emergency Contact		**Relationship to Patient**
Home Phone	**Cell Phone**	**Work Phone**
Secondary Emergency Contact		**Relationship to Patient**
Home Phone	**Cell Phone**	**Work Phone**

Insurance		
Does the patient have medical insurance? ☐ Yes ☐ No	**Primary Health Insurance** _____ Subscriber / Medicaid No: _____ Group No: _____	**Secondary Health Insurance** _____ Subscriber / Medicaid No: _____ Group No: _____

Household Income: ☐ Less than $15,060 ☐ $15,061-$18,825 ☐$18,826-$22,590 ☐$22,591-$26,355 ☐$26,356-$30,120 ☐ More than $30,121 ☐ Don't Know

Number of household dependents

Are you a Veteran? ☐ Yes ☐ No	**Are you a Migrant Worker?** ☐ Yes ☐ No	**Are you a Seasonal Worker?** ☐ Yes ☐ No	**Public Housing?** ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

If yes, please select a living arrangement (Check one): ☐ **Permanent Supportive Housing** (does not have time limits, rent)

☐ **Transitional** (center, community, home)

☐ **Doubling Up** (living with other people for a temporary period and move often)

☐ **Street** (sidewalk, car, park, doorway, public or abandoned building)

☐ **Shelter** (safe havens, temporary overnight housing, armories)

☐ **Other** (hotel, motel, day-to-day single room occupancy)

Authorization for Release of Medical Information and Assignment of Benefits

I hereby assign, transfer, and set over to Legacy Medical Care Inc. all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by the insurance.

I-CARE: Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.

Rx History: Our electronic medical record program accesses your prescription/medication history for us to safely prescribe your medication. By signing this, you authorize us to do so.

PRISMA: Is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes. By signing this, you authorize us to send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

I have received, read, and agreed to the attached terms and conditions of the Registration Packet and acknowledge that I have filled out the included information to the best of my abilities.

Signature:	Relationship to patient, if not patient:	Date:

Office Use Only

Verified All Information Filled Out: ☐ Yes ☐ No **Initial _____** **Entered in eCW:** ☐ Yes ☐ No **Initial/Date:**

Administration Verification entered in each accordingly ☐ Yes ☐ No **Initial/Date:**