BROAD TOP AREA MEDICAL CENTER
4133 Medical Center Drive
Broad Top, PA 16621
Phone: 635-2916 * Fax: 635-3025

HUNTINGDON OFFICE
909 Moore Street
Huntingdon, PA 16652
Phone: 643-1414 * Fax: 635-3025

PATIENT REGISTRATION FORM

Today's Date _____

Patient Last Name: _____ **First Name:** _____**Middle Initial:**____ **Gender:** ☐ **Male** ☐ **Female**	**Address:**_____ _____ **City:**_____ **State:** _____ **Zip:**_____ **Physical Address if different from mailing address:** _____
S. S. Number: _____ **Date of Birth:** _____	**Home Phone:** _____**Work:**_____ **Other Phone:** _____
New Patient: (check) Yes ☐ **No** ☐	**Veteran: Yes** ☐ **No** ☐
Homeless: Yes ☐ **No** ☐ **Migrant Farm Worker: Yes** ☐ **No** ☐	**Preferred method of communication: (Check)** ☐ Phone ☐ U.S. Mail ☐ Other
Marital Status: (Check) Single: ☐ Married: ☐ Widowed: ☐ Divorced: ☐ Other : ☐	**Race: (Check)** White ☐ Black/African American ☐ Asian ☐ Hispanic ☐ Other Pacific Islander ☐ American Indian ☐ Native Hawaiian ☐ More than one Race ☐ Unreported/Refused ☐
Employment: (Check) Employed ☐ Student FT☐ PT ☐ Disabled ☐ Retired ☐ Unemployed ☐ Other ☐ **If employed, name of employer:** _____	**Ethnicity: (check)** ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ unreported/refused **Language Preference:** _____ **Language Difficulties:** _____
Primary Care Physician: _____	
Name of Legal Guardian: _____ **Phone:** _____	
Person to contact for emergencies: _____**Relationship:** _____ **Phone:** _____	

PRIMARY INSURANCE:	**ID # _____**
Subscriber Name: _____	**Employer: _____**
Subscriber's Date of Birth: _____ **Subscriber's SSN: _____**	**Employer Address: _____** **City: _____ State: _____ Zip: _____**
Patients relationship to Subscriber: (Check) Self ☐ Spouse ☐ Child ☐ Other ☐	
SECONDARY INSURANCE:	**ID# _____**
Subscriber Name: **_____**	**Employer: _____**
Subscriber's Date of Birth: _____ **Subscriber's SSN: _____**	**Employer Address: _____** **City: _____ State: _____ Zip: _____**
Patients relationship to Subscriber: (Check) Self ☐ Spouse ☐ Child ☐ Other ☐	
Pharmacy Information: **Name: _____ Telephone #: _____** **Address: _____** **Name: _____ Telephone #: _____** **Address: _____**	

As a Federally Qualified Health Center (FQHC) we are ***required by Federal law*** to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is not reported or disclosed. Thank you for your cooperation.

To complete the form below, check the number of family members in your home in the first column and your income in the column that best describes your situation.

FAMILY SIZE	INCOME	INCOME	INCOME	INCOME
☐ 1	☐ 0-11,670	☐ 11,671-17,505	☐ 17,506-23,340	☐ 23,341 & above
☐ 2	☐ 0-15,730	☐ 15,731-23,595	☐ 23,596-31,460	☐ 31,461 & above
☐ 3	☐ 0-19,790	☐ 19,791-29,685	☐ 29,686-39,580	☐ 39,581 & above
☐ 4	☐ 0-23,850	☐ 23,851-35,775	☐ 35,776-47,700	☐ 47,701 & above
☐ 5	☐ 0-27,910	☐ 27,911-41,865	☐ 41,866-55,820	☐ 55,821 & above
☐ 6	☐ 0-31,970	☐ 31,971-47,955	☐ 47,956-63,940	☐ 63,941 & above
☐ 7	☐ 0-36,030	☐ 36,031-54,045	☐ 54,046-72,060	☐ 72,061 & above
☐ 8	☐ 0-40,090	☐ 40,091-60,135	☐ 60,136-80,180	☐ 80,181 & above
For each additional person over 8 family members add: $4,060				