HOPE CLINIC OF ROSS COUNTY

PATIENT REGISTRATION

PLACE LABEL HERE

TODAY'S DATE: _____ **Date of Birth** _____**Birth Gender: Male**___ **Female**___
REASON FOR VISIT: _____
Is this your: First visit to Hope Clinic _____ A return visit to Hope Clinic _____

[PLEASE PRINT]
Legal Name (First and Last)_____
Age: _____ Date of Birth: _____ Phone _____

DEMOGRAPHICS: □ Non-Hispanic □ Hispanic
Race : □ African-American □ Caucasian □Asian □ Am Indian □ Other_____
Preferred Language: □ English □ Spanish □ Other _____
County of Residence:_____ Are you pregnant _____ Do you smoke/vape_____

THIS STEP IS REQUIRED: **Are you *eligible* to receive medical and/or dental 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 _____

300% Federal Poverty Guidelines for 2025. (For more than 8 people, add $5,500 for each additional person) **REQUIRED: CIRCLE YOUR FAMILY SIZE/INCOME AMOUNT**

Family Size	Annual Income (up to or less than amount listed)
1	$46,950
2	63,450
3	79,950
4	96,450
5	112,950
6	129,450
7	145,950

IF YOU ARE A ***RETURNING PATIENT*** AND YOUR INFORMATION HAS NOT CHANGED, YOU MAY SKIP TO THE SIGNATURE LINE

Street Address_____
City_____State _____ Zip Code _____ County _____
Email _____

EMERGENCY CONTACT INFORMATION:
Name _____Phone: _____

_____
Patient Signature Date