HOPE CLINIC OF ROSS COUNTY

PATIENT REGISTRATION

PLACE LABEL HERE

TODAY'S DATE: _____ Date of Birth _____ 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 _____

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 2024. (For each additional person, add $5,140) **REQUIRED:**
CIRCLE YOUR FAMILY SIZE/INCOME AMOUNT

Family Size	Annual Income (up to or less than amount listed)
1	$45,180
2	61,320
3	77,460
4	93,600
5	109,740
6	125,880

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: _____

DEMOGRAPHICS: □ Non-Hispanic □ Hispanic
Race : □ African-American □ Caucasian □Asian □ Am Indian □ Other_____
Preferred Language: □ English □ Spanish □ Other _____

_____
Patient Signature Date