

Client Registration Information

Please complete this registration form and return it to the check-in desk. The information on this form is considered private and will not be shared except for the provision, support, and billing of your health care services.

Please Print

Name: _____

Date of Birth: Last _____ / First _____ / Middle Initial _____ Maiden/Other Last Name _____
Month Day Year Sex: Male Female

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Have you ever been seen at our clinic before: Yes No When? _____

Please tell us about your CURRENT living situation.

Last night, where did you sleep? (check one): A shelter (ES)

Your own home/apartment (NH) Jail, hospital, or other treatment facility (OT) At a friend's or with family because you had nowhere else to go (DU)

Transitional housing (longer term shelter/housing) (TH) On the street or other public area (ST) Other _____ (OT)

Within the LAST YEAR, have you slept at any of these locations (other than your own home or apartment or in a motel) because you had nowhere else to go, or in foster care? YES (AR) NO

Are you of Hispanic/Latino heritage? Yes No Decline to answer

Race (Please check all that apply):

Asian (A) Black or African American (B) Native American or Alaska Native (N) Pacific Islander or Hawaiian Native (P) White (W) Decline to answer (U)

Have you ever served in the U.S. Military? Yes No Decline to answer

Do you need an interpreter? Yes No If Yes, Primary Language: _____

Financial Information (This information will be used to calculate discounted fees)

NO PERSON WILL BE DENIED SERVICE BECAUSE OF INABILITY TO PAY

Total Household Income - Please include all sources before taxes, including: Salary/Wages, DSHS/Welfare Checks, Social Security/SSI, Unemployment, Child Support, etc. Number of people supported on this income

\$ _____ per month \$ _____ per year _____

Insurance Information

Do you have any type of medical insurance coverage: Medicaid coupons, Healthy Options, Basic Health Plan, BHP Plus, CHIP, Commercial Insurance, Medicare, or Other?

Yes (Please show your medical coupon/insurance card at check-in) No

Please read and sign below:

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the medical provider. I am financially responsible for any balance due. I authorize the medical provider or Insurance Company to release any information required for this claim. I certify that the above information is accurate, to the best of my knowledge.

Consent for Treatment: I hereby grant permission to the STD Clinic at Harborview Medical Center, a contractor of Public Health-Seattle & King County, to perform such medical and therapeutic procedures as may be professionally deemed necessary or advisable for my diagnosis and treatment. I understand my lab sample may be stored and re-tested to check the quality of our lab methods.

Signature _____ Date _____ Patient Parent Guardian

OFFICE USE ONLY

New Update Make HR ID# (Pt ID# if no chart): _____

Clerk Initials _____ Pay Status: **A** **B** **C** **D** **E**

Public Health
Seattle & King County



Client Registration:STD

HIV/STD Program
STD Clinic at Harborview
325 Ninth Avenue, Box 359777
Seattle, WA 98104
Form #: PH-STD-1140 (Rev. 4/11)

Phone: 206-744-3590
Fax: 206-744-8771

Client Name: _____

HR #: _____

D.O.B.: _____

ANONYMOUS (Your Personal Code Name)	
Your Middle Initial	_____
First two letters of your Mother's Maiden Name	_____
First two letters of your City of Birth	_____
First two letters of your Father's First Name	_____
Your First Name	_____
<i>(Please make sure the above information is accurate. You will need this Code Name to get your results.)</i>	
Your Birthdate	_____ / _____ / _____

Sex: Male Female
 Zip: _____

Client Registration:STD

Client Name: _____
HR #: _____
D.O.B.: _____