QUEST CENTER FOR INTEGRATIVE HEALTH

Agency Registration Form

Today's Date: _____

Basic Info: ***While Quest recognizes a spectrum of gender/sex, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex on record with your insurance must be used on documents pertaining to insurance and billing. However, please also let us know the gender, name, and pronouns that you would like us to use.***

_____

Legal Last Name | Legal First Name | MI | Preferred Name | Date of Birth

_____

Street Address | Unit/Apt # | City | State | Zip

County: _____ Housing Status: ☐ Permanent ☐ Temporary ☐ Houseless ☐ Other: _____

Birth Gender: ☐ F ☐ M ☐ Intersex Legal gender: ☐ F ☐ M Pronoun: ☐ She ☐ He ☐ They ☐ Other: _____

Gender Identity: ☐ Female ☐ Genderqueer/Non-Binary ☐ Trans ☐ Male ☐ Other:_____

Contact Info:

Phone Number:	Cell:	Work:	Home:
OK to leave message?	☐ Yes / ☐ No	☐ Yes / ☐ No	☐ Yes / ☐ No

Email: _____ Appointment reminders via: ☐ Phone Call ☐ E-Mail ☐ No reminders

Would you like: Access to the Patient Portal? ☐ Yes ☐ No To receive Quest's Electronic Newsletter? ☐ Yes ☐ No

Billing Information:

Insurance: ☐ Medicaid/OHP ☐ Medicare ☐ VA ☐ IHS ☐ Self-Pay ☐ Uninsured ☐ Private:_____

_____ Primary Insurance Carrier | _____ Insurance ID Number | _____ Secondary Insurance Carrier, if applicable

_____ Policy Holder's Name (If not you) | _____ Policy Holder's Date of Birth | _____ Relationship to You

_____

Emergency Contact Name | Relationship to you | Phone | Alt. Phone

_____

Street Address | Unit/Apt # | City | State | Zip Code

Demographics: *Your optional responses help Quest develop culturally responsive and inclusive programs. As a Non-Profit, we collect this data in order to secure funding for marginalized populations, but understand that one's identity can't be reduced to a series of boxes.*

Do you think of yourself as: ☐ Lesbian/Gay ☐ Straight/Hetero ☐ Bi/Pan-sexual ☐ Queer ☐ Asexual ☐ Other

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Poly ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Appx. monthly income? $_____ How many people (including you) does your income support?_____

Please choose all options that best describe your racial or ethnic heritage:

☐ Black/African American ☐ White/European ☐ Middle Eastern/North African ☐ Asian: _____

☐ Native/Indian/Indigenous American:_____ ☐ Alaska Native/Eskimo ☐ Native Hawaiian/Pacific Islander

☐ Hispanic ☐ Latin American/Latinx/Caribbean:_____ ☐ Mexican/Chicanx/Xicanx ☐ Other:_____

Military Status: ☐ N/A ☐ Active Duty ☐ Veteran ☐ Discharged ☐ Reserve

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Agency Registration Form

Today's Date: _____

Medical Information:

_____

Primary Care Physician | Clinic Name | Location | Phone

_____

Preferred Hospital | Location

For Motor Vehicle Accidents Only: ☐ Does Not Apply

_____

Date of Accident | Claim # | Name of Claim's Adjuster | Phone

_____

Attorney's Name (If Applicable) | Attorney's Address | Phone

HIV Status: ☐ HIV Positive ☐ Unknown Status ☐ HIV Negative

Would you like to be contacted about HIV Testing or Support Services?: ☐ Yes ☐ No ***(If No, skip to next section)***

When calling, can we identify as HIV Services? ☐ Y ☐ N Does Emergency Contact know your HIV status? ☐ Y ☐ N

Would you like to receive monthly HIV Services mailings? : ☐ E-Mail:_____ ☐ US Post ☐ No, thanks!

Do you have CareAssist? ☐ Yes ☐ No HIV Primary Care Clinic: _____

Are you Ryan White eligible? ☐ Yes ☐ No ☐ Unsure Do you identify as a long-term survivor? ☐ Yes ☐ No ☐ Unsure

Program of Entry: *Which program(s) are you primarily here for?* ☐ W.I.S.H. Pain Management ☐ Mental Health ☐ Finding & Sustaining Recovery (FSR) ☐ Recovery Mentors ☐ Nutrition Night ☐ Ryan White Mental Health ☐ HIV Peer Support ☐ Women of Wisdom (WOW) ☐ Acupuncture ☐ Naturopathy ☐ Osteopathy

- Are you a: ☐ New client ☐ Returning Client

Referral Source: ☐ Health Provider ☐ Social Service Provider ☐ Insurance Company ☐ Self ☐ Ad/Brochure ☐ Internet Search ☐ Quest Client/Provider ☐ Other ***Name of Referral Source**:_____

Please complete if you are a Youth under the age of 18 and/or have a legal guardian: ☐ N/A

_____

Parent/Guardian Name | Primary Phone: | Alt. Phone:

May we leave a message identifying as Quest? ☐ Yes ☐ No

_____

Street Address | Unit/Apt # | City | State | Zip Code

I certify that the above information is true and accurate:

_____ _____ _____ _____

Client/Patient Signature | Date | Parent/Guardian Signature | Date

For Business Office Use Only: Ind. Entering Data:_____ Date Entered:_____