POSITIVE ASSISTANCE, INC. (501) C3 dba INCLUSIVE CARE OF ORLANDO

750 S. Orange Blossom Trail, Suite 222, Orlando, FL 32805 | 7156 West Colonial Drive, Orlando, FL 32818

Phone: 877-801-4086 | 407-412-6569 | Fax: 407-930-9443 | www.PositiveAssistance.org

PATIENT REGISTRATION FORM

Patient's Last Name: ____________________________ First Name: ___________________________ Middle (Initial): _________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: ____ Email Address: _____________________________________

Phone: __________________________ ☐ Home ☐ Cell ☐ Okay to send appointment reminders via text message

Date of Birth: ____________ SSN: _________ - ____ - _________ Preferred Name : ________________________________

Sex Assigned at Birth: ☐ Male ☐ Female | Preferred Pronoun: _______ | Gender Identity: ☐ Male ☐ Female ☐ Trans

Occupation: _____________________ Employer: _______________________ Employer Phone: _______________________

FINANCIAL INFORMATION

Family Size: ___ Yearly Gross Income: ______ Initials: ____ FPL: ____% Sliding Fee Scale: _______ Eligibility Date: ________

INSURANCE INFORMATION

☐ Private Insurance ☐ Medicaid ☐ Medicare Part D ☐ Other Initials: _________

HOW DID YOU HEAR ABOUT US?

☐ Insurance Plan ☐ Physician/Provider ________________ ☐ Close to Home/Work ☐ Family

☐ Hospital: ___________________ ☐ PA Radio Talk Show/Social Media ☐ Friend ☐ Walk In

MISCELLANOUS INFORMATION

Preferred Language	Race	Ethnicity	Preferred Method of Communication
☐ English	☐ Native/American Indian	☐ Hispanic or Latino	☐ Cell Phone Text
☐ Spanish	☐ Asian	☐ Non-Hispanic or Latino	☐ Cell Phone Call
☐ Haitian Creole/French	☐ Black/African American	☐ Native American	☐ Home Phone Call
☐ Portuguese	☐ White/Caucasian	☐ Other	☐ Email
☐ Other	☐ Other		

I certify that the above information is a true and complete statement of my financial and insurance situation to the best of my knowledge. I understand that the information I have given is subject to verification by Positive Assistance, Inc. and every effort will be made to keep my information private and confidential. I also understand that I may request a review of the charge(s) if I feel it is inaccurate. For family planning and communicable disease services, I understand that I will not be denied service(s) because of inability to pay.

____ ____________________

Signature of Patient **Date**

____ ____________________

Staff Name, Signature, or Initials **Date**