VICTORY HEALTH PARTNERS
REGISTRATION FORM

Today's Date: ____ /____ /____ Chart Number: _____ Office Payment: $_____

Patient Information		
Last Name:	**First Name**	**Middle Initial:**
☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Home Phone #: ( )
		Cell Phone #: ( )
Street Address:		Apt. #:
City:	State: Zip:	P.O. Box:
Employer:	Occupation:	Employer Phone #: ( )
Race:	Social Security #:	Sex: ☐ M ☐ F
Age	Date of Birth:	Email:

Spouse's Information		
Spouse's Name:	Social Security #:	Birth Date: / / Age:
Is Spouse a patient: ☐ Yes ☐ No	Race:	Sex ☐ M ☐ F
Phone #: ( )	Employer:	Occupation:
Employer Phone #: ( )		

Income Information
Check all that apply to your household: ☐ Salary & Wages ☐ SSI ☐ Social Security Retirement ☐ Pension ☐ Unemployment ☐ Workman's Comp ☐ Child Support/Alimony ☐ Social Security Disability ☐ Rental Income ☐ Pension ☐ Other
If you are receiving Social Security Disability, what month and year will you become eligible for medicare? ____/___

Family Size
Count all persons dependent on your household income: # of Adults: # of Children:
U.S Citizen? ☐ Yes ☐ No If not a citizen, name your country of citizenship:

CONTINUE ON BACK

Please List All Household Members			
NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #

PATIENT HISTORY
Have you been to the emergency room in the past 12 months? ☐ Yes ☐ No
If yes, which hospital? _____ Month/year of hospitalization: _____ / _____
Did that hospital refer you to Victory Health Partners? ☐ Yes ☐ No
Were you referred to the clinic by: ☐ Doctor ☐ Hospital ☐ Family Friend ☐ TV/Radio/Newspaper ☐ Church ☐ Yellow pages (Check One Box Please) Other_____
Church or religious affiliation: _____

IN CASE OF EMERGENCY CALL		
Name:	Relationship:	
Cell Phone:	Work Phone:	Home Phone:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance in office visits and dispensary fees. I also authorize Victory Health Partners to release any information required to process my application.

Patient Signature_____**Date**_____

Interviewer _____**Date**_____

Victory Health Partners is a non profit health care organization providing quality care to low income uninsured adults in the Mobile area. Victory does not accept insurance or government funding, but instead relies on the generous support of churches, individuals, foundations, and businesses of the Greater Mobile Area.