

Community Health Center of Franklin County
Desmond Callan Community Health Center
REGISTRATION FORM 2011

Please answer the following questions about yourself so that we can best assist you. Any information you provide to us now or during your visits is confidential. Please provide our staff with a photo ID to help us protect you from identity theft.

Patient Information

Last Name _____
First Name _____ MI _____
Mailing Address _____
City _____
State _____ Zip _____
Home Phone _____
Work/Cell Phone _____
Email _____
Date of Birth _____ Sex _____
Social Security # _____
Marital Status _____
Emergency Contact _____
Relationship _____
Emergency Phone _____

Patient Medical Background

Doctor: _____
Location: _____
Dentist: _____
Location: _____
Pharmacy: _____
Location: _____
Do you use Tobacco? Yes In Past Never

Insurance and Payment

Who is responsible for payment (guarantor)?
Name: _____
Date of Birth: _____
SSN: _____
Relationship: _____
Do you have medical insurance? Yes No
Plan(s): _____
Do you have dental insurance? Yes No
Plan(s): _____

Answering these optional questions will help us plan our services better and secure funding to meet the needs of our patients.

Language:

Do you speak English? Yes No Some
What is your preferred language? _____
Do you need a translator? Yes No

Income and Employment:

Family Size: _____ Adults _____ Children
Household Estimated Income: _____
 Weekly Monthly Yearly
Are you employed? Full time Part Time
 Retired or Disabled Student Unemployed
Occupation: _____
Employer/School: _____

Additional Services:

Are you a Veteran? Yes No
Are you a farm worker? Yes No
If yes, are you Full Time Seasonal Migrant
Are you homeless? Yes No
Do you have transportation? Yes No

Race and Ethnicity:

Are you Hispanic/Latino? Yes No
What is your Race (check all that apply):
 Asian Native Hawaiian/Pacific Islander
 Black/African American White/Caucasian
 American Indian or Alaska Native

How did you hear about us? Radio TV
 Newspaper Poster Community Event
 Friend or Family Member Agency Referral
 Other _____

Consent and Release:

I hereby authorize the Community Health Center of Franklin County to provide treatment as necessary for me and my family, including emergency care if necessary. I also authorize release of all necessary information to my insurance company, payer, and/or medical/dental provider for the purpose of payment or providing continuing treatment. I assign the Community Health Center of Franklin County to claim and collect insurance benefits payable for its treatment of me and my family. I understand that I may be responsible for payment of any service not covered by insurance or other benefits, including claims occurring under accident coverage such as workers compensation or automobile insurance. I understand that my insurer may require me to have a CHCFC provider designated as my PCP to have my medical visits covered.

Signature of patient or parent/legal guardian

Date

Annual Review (2012) Signature of patient or parent/guardian

Date