CHCFC
Community Health Center of Franklin County

Patient Registration Form

Date: _____

Please register me for:	☐ Medical Services	☐ Dental Services	☐ Behavioral Health Services
Location:	☐ Greenfield	☐ Orange	☐ Baystate (Urgent Dental Only)

Patient Information

Today's Date: _____

Legal Name (First & Last): _____

Preferred/Current Name: _____ Pronouns: _____

Sex Assigned at Birth*: ☐ Female ☐ Male ☐ Non-Binary ☐ Other ☐ Unknown ☐ X

**While CHCFC recognizes a number of genders/sexes, many insurance companies and legal entities do not. Please know that we are required to use the name and sex listed on your insurance for documents related to insurance, billing and correspondence. During your visit and everywhere else we'll use your current name and pronouns.*

Date of Birth: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ ☐ Cell ☐ Home ☐ Work

Phone 2: _____ ☐ Cell ☐ Home ☐ Work

Email Address: _____

*All parents with custodial rights information should fill out the information below.

Parent/Guardian Name (if applicable): _____

Parent/Guardian Name (if applicable): _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Preferred Pharmacy: _____

Insurance and Payment Information

Do you have Medical Insurance? ☐ Yes ☐ No

Name of Policy Holder: _____ Date of Birth: _____

Phone #_____ Address_____ Employment Status_____

Relationship to Policy Holder: _____

Primary Plan: _____ Policy/ID Number: _____

Secondary Plan:_____ Policy/ID Number: _____

Do you have Dental Insurance? ☐ Yes ☐ No

Primary Plan: _____ Policy/ID Number: _____

Secondary Plan:_____ Policy/ID Number: _____

Would you like to apply for our sliding fee scale? ☐ Yes

Would you like help with insurance enrollment? ☐ Yes

Turn Over!

Ethnicity

☐ Hispanic/Latino/Latinx ☐ Puerto Rican
☐ Non-Hispanic ☐ Cuban
☐ Mexican/Mexican American ☐ Declined
☐ Other, please specify: _____

Race (select one or more)

☐ Black or African American
☐ White ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Declined ☐ Some other Race

Marital Status

☐ Married/Partnered
☐ Single
☐ Divorced
☐ Legally Separated
☐ Widowed
☐ Child
☐ Significant Other
☐ Domestic Partner

Gender Identity

☐ Female ☐ Male ☐ Intersex ☐ Non-Binary
☐ Transgender Male (FTM)
☐ Transgender Female (MTF)
☐ Genderqueer, neither exclusively male nor female
☐ Other, please specify: _____
☐ Choose not to disclose

Religion

_____

Public Housing

☐ Yes ☐ No

Sexual Orientation

☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please describe: _____
☐ Don't know
☐ Choose not to disclose

Family Financial Information

Family/Household Size: _____
Income $_____

☐ Weekly ☐ Monthly
☐ Bi-weekly ☐ Annually
☐ Salary ☐ Pension
☐ Gov. Assistance ☐ Social Security

Language

Primary Language/Written Language

_____

Would you like a translator for your appointment? ☐ Yes ☐ No

Employed In Healthcare?

☐ Yes ☐ No

Resident in Congregate Housing?

☐ Yes ☐ No

Work & Housing

What is your employment status?

☐ Employed ☐ Disabled
☐ Self Employed ☐ Full Time Student
☐ Unemployed ☐ Part Time Student
☐ Retired

Employer_____

Are you a CHCFC employee? ☐ Yes ☐ No

Are you a farmworker? ☐ Yes ☐ No
If yes, what is your status?
☐ Seasonal
☐ Migrant

Are you currently homeless? ☐ Yes ☐ No
Are you a veteran? ☐ Yes ☐ No
Branch_____

Transportation

Do you need help with transportation to your appointments? ☐ Yes ☐ No

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.

X_____

Signature of patient or parent/legal guardian **Date**

Staff Initials: _____