



2019 REGISTRATION FORM

Office/Service(s) Registering For:

Greenfield Dental Greenfield Medical Behavioral Health Orange Dental Orange Medical

Patient Information

Last Name: _____
First Name: _____ MI: _____
Preferred Name: _____
Preferred Pronouns: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Date of Birth: _____ SSN: _____
Marital Status: _____
Emergency Contact: _____
Address: _____
City: _____ State: _____ Zip: _____
Relationship: _____
Emergency Phone: _____
Pharmacy: _____

Sexual Orientation & Gender Identity (SOGI)

What sex were you assigned at birth?

Male Female

What is your current gender identity?

Male Female Gender Queer
 Transgender Male Transgender Female
 Other please specify _____
 Choose not to disclose

Do you think of yourself as:

Lesbian, gay, or homosexual
 Straight or heterosexual
 Bisexual Something Else
 Don't know Choose not to disclose

Do you identify as Transgender or Transsexual

Yes No

Race & 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

Insurance and Payment

Who is responsible for payment (Guarantor)

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ SSN: _____
Relationship: _____
Do you have Medical Insurance? Yes No
Primary Plan: _____
Secondary Plan: _____
Do you have Dental Insurance? Yes No
Primary Plan: _____

Family Income & Patient Employment/Student Status

Family Size: _____ Adults: _____ Children: _____
Household Estimated **Yearly** Income:
 <\$10,000 \$10-\$20,999 \$21-\$30,999
 \$31-\$40,999 \$41-\$50,999 \$51-\$60,999
If over \$70,000 enter here: _____
Are you employed? Full time Part Time
 Retired Disabled Student Unemployed
Occupation: _____
Employer/School: _____

Language

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

Additional Services (check all that apply):

Veteran Homeless
 Farmworker (*If so, please select one below*)
 Full Time Seasonal Migrant
Do you have transportation? Yes No

How did you hear about us?

Friend or Family Agency Referral
 Newspaper Facebook Community Event
 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