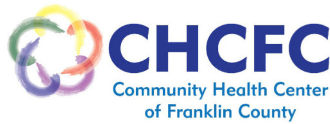

2019 REGISTRATION FORM

Office(s) Registering For:

☐Greenfield Dental ☐Greenfield Medical ☐Orange Dental ☐ Orange Medical

Patient Information

Last Name:____________________
First Name:__________________MI:____
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: ____________________

Income & Employment

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.

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