2020 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.

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