Norwalk Community Health Center

Patient Registration Form

Today's Date: _____ **Primary Language Spoken:** _____

Patient Name: _____
(Last) **(First)** **(Middle)**

Date of birth: _____ **Social Security:** _____

Patient's Address: _____
(Street) **(City)** **(Zip)**

Mailing Address (If different): _____
(Street) **(City)** **(Zip)**

Home Telephone: _____ **Cell:** _____ **Email:** _____

Gender: ☐ Male ☐ Female ☐ Transgender Male/Trans Man/FTM
☐ Transgender Female/Trans Woman/MTF ☐ Genderqueer
☐Additional identity (fill in) _____ ☐ Decline to state

What sex were you assigned at birth? ☐ Male ☐ Female ☐ Decline to state

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual
☐ Something else ☐ Don't know ☐ Choose not to disclose

What is your preferred name and what pronouns to you prefer (e.g. he/him, she/her):

_____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced

Race:
☐Black or African American
☐Asian
☐Caucasian
☐Multiracial
☐America Indian / Alaska Native / Inuit
☐Pacific Islander
☐Other

Ethnicity:
☐ Hispanic / Latino / Latina
☐ Not Hispanic / Latino / Latina

Housing Status:

☐ Living in shelter

☐ Living with friend or relative

☐ Private Housing

☐ Public housing

☐ Street

☐ Transitional Living

Veteran Status:

☐ Veteran

Military Branch: _____

☐ Not a Veteran

Legal Guardian: _____

(Last) **(First)** **(Middle)**

Telephone: _____

Guardian Relationship:

☐ Father ☐ Mother

☐ Legal Guardian ☐ Foster Parent

☐ Grandparent ☐ Conservator

☐ Power of Attorney ☐ Other: _____

Emergency Contact

Emergency Contact: _____ **Relationship**: _____

Phone: _____ **Does this person know you are a patient?** ☐Yes ☐No

Pharmacy Information

Primary Pharmacy: _____ **Phone #:**_____

Address: _____

Financial Information

Household Income: $_____ ☐Yearly ☐Monthly ☐Weekly ☐Biweekly

Number of Dependents: _____ (Include spouse and children under 18 years old)

Name of Primary Insurance Company: _____

Policy ID#: _____ **Group #:**_____

Policy Holder Name: _____ **Relationship:** _____

Policy Holder's Date of Birth: _____ **Social Security#**:_____

Secondary Insurance Company Name:

_____

Policy ID#: _____ **Group #:**_____

Policy Holder Name: _____ **Relationship:** _____

Policy Holder's Date of Birth: _____**Social Security#:**_____

General Consent
for Treatment and Billing

I give Norwalk Community Health Center (NCHC) permission to provide necessary medical, behavioral health and/or dental evaluation and treatment.

1. I allow NCHC to file for insurance benefits to pay for the care received. I understand that:

    - Norwalk Community Health Center may have to send my medical record information to my insurance company
    - I must pay my share of the costs
    - I must pay for the cost of these services if my insurance does not pay or I do not have insurance

2. I understand:

    - I have the right to refuse any procedure or treatment.
    - I have the right to discuss all medical treatments with my provider.

I declare that the information listed above is accurate and complete. I understand that I may be asked for evidence to verify the statement of income and family size.

_____ _____

Print Patient Name/Parent or Guardian (for children under 18) Date

_____

Signature of Patient/Parent or Guardian (for children under 18)

Acknowledgement of Receipt

Patient Name: _____
(Last) **(First)** **(Middle)**

Date of birth: _____

By signing this form, I am acknowledging that:

- I am either the patient or the patient's legal guardian or personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Norwalk Community Health Center, Inc.;
- I have received the Norwalk Community Health Center's Patient's Bill of Rights in a language I can understand;
- I understand that I may contact Norwalk Community Health Center Inc. at any time in the future if I have questions about the content of the Notice of Practice and/or the Patient's Bill of Rights.

Please sign and date this acknowledgement form.

_____ _____
Print Patient Name/Parent or Guardian (for children under 18) Date

_____ _____
Signature of Patient or Parent/Guardian (for children under 18) Date