



PATIENT REGISTRATION FORM

Verified By: _____
 DATE REC/ENTERED: ____/____/____
 STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY

MEDICAL DENTAL Riverside Safe Harbor Pearl Street Pine Street

PATIENT INFORMATION

LASTNAME			FIRSTNAME			MI					
STREET ADDRESS			CITY			STATE			ZIP		
SOCIAL SECURITY #			DATE OF BIRTH			HOME PHONE			DAY PHONE		
EMAIL ADDRESS				GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER				GENDER FOR INSURANCE PURPOSES <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union			RACE <input type="checkbox"/> African-American <input type="checkbox"/> Native American <input type="checkbox"/> Asian-American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Multi-racial				Primary Language if Not English: _____ Do You Need Interpreter Services? <input type="checkbox"/> YES <input type="checkbox"/> NO Ethnicity/Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic				
Primary Care Physician			AGRICULTURAL WORKER <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal			Are You a U.S. Veteran? <input type="checkbox"/> YES <input type="checkbox"/> NO			FAMILY FINANCIAL INFORMATION Family/Household Size: _____ Household Income: \$ _____ As a Health Center that receives Federal Funding, we are required to collect this information. All answers are confidential.		
HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> Hospital Referral <input type="checkbox"/> Outreach Worker <input type="checkbox"/> Friend <input type="checkbox"/> Facebook <input type="checkbox"/> Doctor/Dentist Referral <input type="checkbox"/> Emergency Room Referral <input type="checkbox"/> Work <input type="checkbox"/> Other: _____ <input type="checkbox"/> Telephone Book <input type="checkbox"/> Newspaper <input type="checkbox"/> Website											
HOUSING STATUS Are You Homeless? <input type="checkbox"/> YES <input type="checkbox"/> NO If homeless, are you: <input type="checkbox"/> Doubling Up (living w/others) <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional <input type="checkbox"/> Unknown											

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

Patient (18 years or older) Custodial Parent Guardian (proof of legal status required for treatment) Foster Parent (proof of legal status required for treatment)

LASTNAME			FIRSTNAME			MI					
STREET ADDRESS			CITY			STATE			ZIP		
SOCIAL SECURITY #			DATE OF BIRTH			HOME PHONE			RELATIONSHIP TO PATIENT		

DENTAL INSURANCE INFORMATION	MEDICAL INSURANCE INFORMATION
<input type="checkbox"/> I currently have DENTAL insurance (see below) <input type="checkbox"/> I currently DO NOT have DENTAL insurance <input type="checkbox"/> I would like to apply for the SLIDING FEE SCALE Dental Insurance Name: _____ Policy Number: _____ Group Number: _____ Billing Address for Insurance: _____ _____ Policy Holder's Name: _____ Policy Holder's DOB: _____ Policy Holder's Employer: _____ Phone Number for Insurance: _____	<input type="checkbox"/> I currently have MEDICAL insurance (see below) <input type="checkbox"/> I currently DO NOT have MEDICAL insurance <input type="checkbox"/> I would like to apply for the SLIDING FEE SCALE Medical Insurance Name: _____ Policy Number: _____ Group Number: _____ Billing Address for Insurance: _____ _____ Policy Holder's Name: _____ Policy Holder's DOB: _____ Policy Holder's Employer: _____ Phone Number for Insurance: _____

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

I understand that to the best of my knowledge that the preceding answers are true and correct. _____
 Signature of Patient or Personal Representative



Consent to Treatment and Consent to Release of Health Information for Treatment, Payment and Health Care Operations

I. Consent to Treatment

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Center of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care; social services; and/or mental health and drug and alcohol screening, assessment, diagnosis and treatment.

II. Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health and other treatment and health records and information (such health records and information are referred to in this Consent as my "Health Information") by CHCB for the following purposes:

A. Use of Health Information By or For CHCB for Treatment and for Health Care Operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including, for example, financial or quality assurance audits and training.

B. Disclosure of Health Information to Persons Outside CHCB for Treatment Purposes and for Payment

- Providing Health Information to other health providers or agencies who are or will be involved in my care (except for treatment information concerning drug or alcohol abuse, for which a separate consent is required);
- Providing all necessary Health Information as determined by CHCB, including information about treatment for drug or alcohol abuse, to Fletcher Allen Health Care if I am referred there for treatment.
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for CHCB services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my CHCB Registration form or other updated insurance information on file with CHCB.

III. Other Matters

I understand that I have the right to revoke this Consent at any time, but revoking this Consent will not affect any actions which were taken by CHCB in reliance on this Consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition: _____.
If none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on use or disclosure of my Health Information for the purposes described in this Consent and that CHCB may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of Health Information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed Consent.

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

I have read all of the information above and I understand and consent to its content.

Name of Patient (please print)

Signature of Patient or Personal Representative

Date of Birth: _____

Date: _____

Name of Personal Representative (please print): _____



617 Riverside Avenue Burlington, VT 05401
(802) 864-6309

Patient Name: _____ **DOB:** _____

PERMISSION TO RELEASE PATIENT INFORMATION

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, test results, etc., we **will not** give that information out unless his/her name(s) is provided for our records. I hereby give permission to the Community Health Center of Burlington to allow receipt of the following to those listed below should he/she call or come in to inquire. Please check what you will allow to be released.

- Medical Test Results
- Medications
- Appointment Confirmation

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- I **do not** consent to information about me to be released to others, except as I have consented, or may in the future consent in other authorizations or consents provided to me by the Community Health Center of Burlington, or as required by law.

Patient at the Community Health Center of Burlington consent to disclosure of information for purposes of treatment, payment and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.

Patients requesting information in regards to drug and alcohol counseling/treatment need to complete a separate authorization. No drug and alcohol information will be given out with this permission.

USE OF E-MAIL

I understand that CHCB and I may exchange information via e-mail per my request.

- I do wish to have CHCB contact me via e-mail. This may include appointment confirmations.
- I **do not** wish to have CHCB contact me via e-mail.

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. CHCB's Notice of Privacy Practice states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in this Notice
- The person to contact for further information about our Privacy Practices

We are required by law to give you a copy of this notice and obtain your written acknowledgement that you have received a copy of the Notice.

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices, I have completed the Permission to Release Patient Information and have completed and understand the use of e-mail.

Patient's Name: _____

Signature of Patient or Patient's Representative: _____

Description of Legal Authority to Act on Behalf of the Patient: _____

Date: _____