community health centers OF BURLINGTON

PATIENT REGISTRATION FORM

Verified By:

DATE REC/ENTERED: ____/____/____

STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY ☐ **MEDICAL** ☐ **DENTAL**

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ GoodHEALTH ☐ Winooski Family

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in Black or Blue Pen Only*

LAST NAME | FIRST NAME | MI | NICKNAME/CHOSEN NAME

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE | CELL PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____

Do You Need Interpreter Services? ☐ YES ☐ NO

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION

Family/Household Size: _____

Household Income: $ _____

☐ Weekly ☐ Annually
☐ Biweekly ☐ Refused
☐ Monthly

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

LEGAL SEX
☐ MALE
☐ FEMALE

CURRENT GENDER
☐ MALE
☐ FEMALE

PRONOUNS (Optional):

_____

GENDER IDENTITY
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ GENDERQUEER
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO

If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

PREFERRED PHARMACY

PHARMACY NAME | PHARMACY LOCATION

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE NUMBER

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)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

DENTAL INSURANCE INFORMATION

☐ **I currently have DENTAL insurance (see below)**

☐ **I currently DO NOT have DENTAL insurance**

☐ **I would like to apply for the SLIDING-FEE SCALE**

Dental Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary DENTAL insurance (see below)**

Dental Insurance Name: _____

Policy/ID Number: _____

MEDICAL INSURANCE INFORMATION

☐ **I currently have MEDICAL insurance (see below)**

☐ **I currently DO NOT have MEDICAL insurance**

☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary MEDICAL insurance (see below)**

Medical Insurance Name: _____

Policy/ID Number: _____