



DATE REC/ENTERED:
STAFF INITIALS:

PATIENT REGISTRATION FORM

LOCATION: RIVERSIDE SAFE HARBOR PEARL STREET SOUTH END CHAMPLAIN ISLANDS GOOD HEALTH WINOOSKI ESSEX

PATIENT DEMOGRAPHICS (PLEASE FILL OUT ENTIRE FORM IN BLACK OR BLUE PEN ONLY)

LAST NAME	FIRST NAME	MIDDLE INITIAL	CHOSEN NAME (IF ANY)
-----------	------------	----------------	----------------------

STREET ADDRESS	CITY	STATE	ZIP CODE
----------------	------	-------	----------

MAILING ADDRESS (IF DIFFERENT THAN PHYSICAL ADDRESS)

SOCIAL SECURITY NUMBER	DATE OF BIRTH	PRONOUNS
------------------------	---------------	----------

CELL PHONE	WORK PHONE	HOME PHONE
------------	------------	------------

EMAIL ADDRESS	PREFERRED CONTACT METHOD
---------------	--------------------------

SEX AT BIRTH <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	CURRENT GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	GENDER IDENTITY <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> TRANSGENDER MALE (FEMALE-TO-MALE) <input type="checkbox"/> TRANSGENDER FEMALE (MALE-TO-FEMALE) <input type="checkbox"/> GENDERQUEER <input type="checkbox"/> OTHER <input type="checkbox"/> CHOOSE NOT TO DISCLOSE	SEXUAL ORIENTATION <input type="checkbox"/> STRAIGHT OR HETEROSEXUAL <input type="checkbox"/> LESBIAN, GAY, OR HOMOSEXUAL <input type="checkbox"/> BISEXUAL <input type="checkbox"/> SOMETHING ELSE <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> CHOOSE NOT TO DISCLOSE
---	---	---	--

PRIMARY LANGUAGE	DO YOU NEED INTERPRETER SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO
------------------	---

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	ARE YOU A U.S. VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU AN AGRICULTURAL WORKER? <input type="checkbox"/> NO <input type="checkbox"/> MIGRANT <input type="checkbox"/> SEASONAL
--	---	--

HOUSING STATUS
 ARE YOU HOMELESS? YES NO
 IF HOMELESS, ARE YOU: DOUBLING UP (LIVING WITH OTHERS) SHELTER STREET TRANSITIONAL UNKNOWN

RACE (SELECT ALL THAT APPLY)

ASIAN	NATIVE HAWAIIAN OR PACIFIC ISLANDER	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR ALASKA NATIVE	WHITE	CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> CHINESE	<input type="checkbox"/> NATIVE HAWAIIAN	<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE	<input type="checkbox"/> WHITE	<input type="checkbox"/> CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> VIETNAMESE	<input type="checkbox"/> OTHER PACIFIC ISLANDER				
<input type="checkbox"/> ASIAN INDIAN	<input type="checkbox"/> GUAMANIAN OR CHAMORRO				
<input type="checkbox"/> KOREAN	<input type="checkbox"/> SAMOAN				
<input type="checkbox"/> FILIPINO					
<input type="checkbox"/> JAPANESE					
<input type="checkbox"/> OTHER ASIAN					

ETHNICITY

HISPANIC, LATINO/A, OR SPANISH ORIGIN	NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN	CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO	<input type="checkbox"/> NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN	<input type="checkbox"/> CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> PUERTO RICAN		
<input type="checkbox"/> CUBAN		
<input type="checkbox"/> HISPANIC, LATINO/A, OR SPANISH ORIGIN		
<input type="checkbox"/> ANOTHER HISPANIC, LATINO/A, AND SPANISH ORIGIN		

FINANCIAL INFORMATION: PLEASE CIRCLE FAMILY SIZE AND ANNUAL HOUSEHOLD INCOME RANGE ON THE TABLE BELOW. ALL RESPONSES ARE CONFIDENTIAL.

HOUSEHOLD ANNUAL INCOME RANGE BASED ON FAMILY SIZE				
1	\$0 to \$15,960	\$15,961 to \$23,940	\$23,941 to \$31,920	\$31,921 & over
2	\$0 to \$21,640	\$21,641 to \$32,460	\$32,461 to \$43,280	\$43,281 & over
3	\$0 to \$27,320	\$27,321 to \$40,980	\$40,981 to \$54,640	\$54,641 & over
4	\$0 to \$33,000	\$33,001 to \$49,500	\$49,501 to \$66,000	\$66,001 & over
5	\$0 to \$38,680	\$38,681 to \$58,020	\$58,021 to \$77,360	\$77,361 & over
6	\$0 to \$44,360	\$44,361 to \$66,540	\$66,541 to \$88,720	\$88,721 & over
7	\$0 to \$50,040	\$50,041 to \$75,060	\$75,061 to \$100,080	\$100,081 & over
8	\$0 to \$55,720	\$55,721 to \$83,580	\$83,581 to \$111,440	\$111,441 & over
9	\$0 to \$61,400	\$61,401 to \$92,100	\$92,101 to \$122,800	\$122,801 & over
10	\$0 to \$67,080	\$67,081 to \$100,620	\$100,621 to \$134,160	\$134,161 & over
*	<i>*ADD \$5,680 PER EACH ADDITIONAL FAMILY MEMBER.</i>	<i>*ADD \$8,520 PER EACH ADDITIONAL FAMILY MEMBER.</i>	<i>*ADD \$11,360 PER EACH ADDITIONAL FAMILY MEMBER.</i>	

DENTAL INSURANCE INFORMATION	MEDICAL INSURANCE INFORMATION
<input type="checkbox"/> I currently have dental insurance. <input type="checkbox"/> I currently DO NOT have dental insurance. <input type="checkbox"/> I would like to apply for the sliding-fee scale.	<input type="checkbox"/> I currently have medical insurance. <input type="checkbox"/> I currently DO NOT have medical insurance. <input type="checkbox"/> I would like to apply for the sliding-fee scale.
DENTAL INSURANCE NAME: POLICY/ID NUMBER: POLICY HOLDER NAME: POLICY HOLDER ADDRESS: POLICY HOLDER PHONE NUMBER: POLICY HOLDER DATE OF BIRTH:	MEDICAL INSURANCE NAME: POLICY/ID NUMBER: POLICY HOLDER NAME: POLICY HOLDER ADDRESS: POLICY HOLDER PHONE NUMBER: POLICY HOLDER DATE OF BIRTH:
SECONDARY DENTAL INSURANCE INFORMATION: DENTAL INSURANCE NAME: POLICY/ID NUMBER: POLICY HOLDER NAME: POLICY HOLDER ADDRESS: POLICY HOLDER PHONE NUMBER: POLICY HOLDER DATE OF BIRTH:	SECONDARY MEDICAL INSURANCE INFORMATION: MEDICAL INSURANCE NAME: POLICY/ID NUMBER: POLICY HOLDER NAME: POLICY HOLDER ADDRESS: POLICY HOLDER PHONE NUMBER: POLICY HOLDER DATE OF BIRTH:

PREFERRED PHARMACY	
PHARMACY NAME	PHARMACY LOCATION

EMERGENCY CONTACT INFORMATION		
NAME	RELATIONSHIP	PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (ANY PATIENT UNDER 18 YEARS OLD MUST HAVE A RESPONSIBLE PARTY)			
<input type="checkbox"/> CUSTODIAL PARENT <input type="checkbox"/> GUARDIAN (PROOF OF LEGAL STATUS REQUIRED FOR TREATMENT AT CHC)			
LAST NAME	FIRST NAME	MIDDLE INITIAL	CHOSEN NAME (IF ANY)
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH	PHONE NUMBER		



Community Health Centers

- RIVERSIDE • SAFE HARBOR • PEARL STREET • SCHOOL-BASED DENTAL CENTER •
- CHAMPLAIN ISLANDS • SOUTH END • GOOD HEALTH • WINOOSKI • ESSEX •

Consent for Treatment

I. Consent for 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 Centers (CHC). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

II. Assignment of Benefits

- A. I authorize CHC to bill and receive payment directly from Medicaid /Medicare or any other insurance carrier for services provided to me.
- B. I hereby assign to CHC all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to me by CHC.
- C. I understand I am responsible for any unpaid balances incurred because of my care at CHC.
- D. I understand that, to the best of my knowledge, the demographic information I have provided is true and correct.
- E. A copy of the CHC payment expectations is available at your request.

III. Termination and restrictions of this consent:

- A. I understand that I have the right to cancel this consent at any time in writing, cancelling this consent will not affect any actions taken by CHC in reliance of this consent before it was cancelled. If not previously cancelled, this consent will end on the following date: _____ . If none is indicated, this consent will end three years after the last date of services to me.
- B. I have read this Consent for Treatment, and I understand and knowingly consent to its content.

REQUIRED

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____