Registration Form

Date:____________________Date of Birth:_________________________Social Security #:__________________
Patient Full Name: ____
Address: ____
City: ____________________________________ State: __________________ Zip: _____________________
Contact numbers: Home___________________Cell Phone:___________________Relative: _________________
Best time to reach you:___________Day_________Night Email address: _______________________________
Age: _______________

Married _____ Widowed _____ Single _____ Separated _____ Divorced _____ Life Partner _____

Student Status: Fulltime______Part-time_______Not a student_____Veteran Status: Yes_____No_____
Smoker: Yes_____No______
Emergency Contact Name:_____________________________________Contact number: ____________________

********** We are required to obtain the following requested information ************

Gender identity: M ___ F ___ Transgender Female to Male ____ Transgender Male to Female ___ Other ____
Choose not to disclose ____

Sexual orientation: Lesbian ___ Gay ___ Straight ___ Bi-sexual ___ Something else ___ Don't know ___
Choose not to disclose_____

Homeless status: Not homeless ___ Doubling up ___ Shelter ___ Street ___ Transitional ___ Public Housing ___

Migrant worker: Migrant_______Not a farm worker_______Seasonal _______No_______Refused to Report_____

Language Barrier: Yes_____No_____What is your primary Language Spoken:____________________________

Race: Native American Indian____Native Hawaiian_____White_____Asian_____Black/African American _____

Other: Pacific Islander___Hispanic ___Alaskan______Declined to specify_____

Ethnicity: Hispanic/Latino_____Not Hispanic _____

Primary Care Provider:________________________________Primary Dentist: ___________________________
Primary Insurance Coverage: ____
Subscribers Name:_______________________________Relationship to Patient: ___________________________
Additional Insurance Coverage: ____
I have trouble getting enough food to eat: Yes ___ No ___ My food needs are met: Yes ___ No ___
Number of family members in household: ____
How did you hear about HHC? ____
We participate in HealthInfoNet to better serve you.

*** Please state your household income in one of the categories listed below ***

We ask for income information because we have many programs that benefit people with lower incomes.

Household income: Weekly ___________ Biweekly ___________ Monthly ____________ Yearly _________

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our Patient Financial Department. Although we will compile the necessary forms to file to your insurance company it is the responsibility of the patient to dispute any services not covered by the insurance company. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

____ ____
Patient Signature Date Signature of guardian if patient is under 18 years Date