



## REGISTRATION FORM

Clinic Location: <input type="checkbox"/> Rutland <input type="checkbox"/> Pediatrics (Rutland) <input type="checkbox"/> Castleton <input type="checkbox"/> Brandon <input type="checkbox"/> Shorewell <input type="checkbox"/> Mettowee				
Patient's first name:		Last Name:	Middle Initial:	Marital Status:
Preferred Name:		Former Name:	Date of Birth:	
Sex (as reported on Birth Certificate): <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown		Sex (identify): <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	Pronouns: <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They <input type="checkbox"/> We <input type="checkbox"/> Other	
Mailing Address:		City:	State:	Zip:
Social Security No.:		Home Phone No.:	Cell Phone No.:	
Email:		Carrier:		
		Work Phone No.:		
Would you like to sign up for the patient portal? (If yes, please make sure email above is completed) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Preferred method of contact: <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone call <input type="checkbox"/> Work phone <input type="checkbox"/> Portal				
Employment Status: <input type="checkbox"/> Active-duty military <input type="checkbox"/> Full-time <input type="checkbox"/> Not currently employed <input type="checkbox"/> Part-time <input type="checkbox"/> Retired			Student Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Not a student <input type="checkbox"/> Part-time	
Pharmacy Name:		Pharmacy Location:		
<b>INSURANCE INFORMATION</b>				
Person Responsible for the Bill:		Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Would you like to speak to someone about getting insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>First Insurance</b>				
Insurance Company Name:		Subscriber's/Insured Name:		
Subscriber's SSN:	Subscriber's Date of Birth:		Relationship to Patient:	
Policy Number:	Group Number:	Effective Date:	Co-pay Amount:	
<b>Second Insurance</b>				
Insurance Company Name:		Subscriber's/Insured Name:		
Subscriber's SSN:	Subscriber's Date of Birth:		Relationship to Patient:	
Policy Number:	Group Number:	Effective Date:	Co-pay Amount:	

**I give my permission for my Healthcare Provider at Community Health to discuss my medical condition and/or test results with:**

**Primary**

Name:		Relationship:		Emergency Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address:		City:		State:	Zip:
Phone No.:					

**Secondary**

Name:		Relationship:		Emergency Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address:		City:		State:	Zip:
Phone No.:					

**PARENT/GUARDIAN INFORMATION**

**First Parent / Guardian**

Name:		DOB:		Relationship:	
Lives with Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:		Cell Phone No.:		Work Phone No.:	
Employer:		Occupation:		Parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Living Together <input type="checkbox"/> Divorced	

Please provide legal custodial/guardianship documentation as appropriate

**Second Parent / Guardian**

Name:		DOB:		Relationship:	
Lives with Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:		Cell Phone No.:		Work Phone No.:	
Employer:		Occupation:			

**PERMISSION TO ACCOMPANY A MINOR**

The persons listed below may accompany my child to appointments at Community Health. I understand that unless the accompanying person's name is listed below, my child will not be seen. I further understand that it is my responsibility to keep these names up to date.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

## DEMOGRAPHIC & FINANCIAL INFORMATION

In order to continue the variety of services offered at Community Health Centers of the Rutland Region and to continue receiving grant funding as a Federally Qualified Health Center (FQHC), Community Health is required to collect demographic information on every patient we serve. The information you provide is confidential. Thank you for choosing Community Health as your healthcare provider.

Patient's first name:	Last Name:	Middle Initial:	Date of Birth:
Household Annual Income (Gross): \$		Number of individuals income supports (household size):	
What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other (specify):			
Would you like an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, which language?	What other language(s) do you speak?	
Race (select all that apply): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other (specify):			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Decline to Answer		Are you a military veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer	
Which best describes your current housing status: <input type="checkbox"/> Permanent (your own house or apartment) <input type="checkbox"/> Doubling Up (staying with someone else) <input type="checkbox"/> Public Housing (government subsidized) <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other (specify):			
Have you been homeless at any time during the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer			
Are you a Agricultural Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please select a class of work: <input type="checkbox"/> Migratory <input type="checkbox"/> Seasonal	
Which best describes you: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Non-citizen immigrant <input type="checkbox"/> Decline to answer <input type="checkbox"/> Refugee <input type="checkbox"/> Other (specify):			
What is your sexual orientation: <input type="checkbox"/> Asexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian/gay <input type="checkbox"/> Pansexual <input type="checkbox"/> Queer <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other (specify)			
What is your gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other (specify):			

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date