DENTAL COMMUNITY HEALTH
MEDICAL • DENTAL • BEHAVIORAL HEALTH

RUTLAND | 69 Allen St., Suites 7 & 10, Rutland, VT 05701 | 802-774-5050
SHORWELL | 2987 VT Route 22A, Shoreham, VT 05770 | 802-897-7716

CHCRR.org

DENTAL REGISTRATION FORM

Patient's first name:	Last Name:	Middle Initial:	Marital Status:
Preferred Name:	Former Name:	Date of Birth:	
Sex (as reported on Birth Certificate): □ M □ F □ Unknown	Sex (identify): □ M □ F □ Unknown	Pronouns: □ He □ She □ They □ We □ Other	
Mailing Address:	City:	State:	Zip:
Social Security No.:	Home Phone No.:	Cell Phone No.: Carrier:	
Email:		Work Phone No.:	
Preferred method of contact: □ Home phone □ Cell phone call □ Work phone □ Portal			
Employment Status: □ Active-duty military □ Full-time □ Not currently employed □ Part-time □ Retired		Student Status: □ Full-time □ Not a student □ Part-time	
Pharmacy Name:	Pharmacy Location:		

DENTAL INSURANCE INFORMATION

Person Responsible for the Bill:	Do you have dental insurance? □ Yes □ No □ Unsure	Would you like to speak to someone about getting insurance coverage? □ Yes □ No

First Insurance

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:

Second Insurance

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 treatment with:

Primary

Name:	Relationship:	Emergency Contact: □ Yes □ No	
Street Address:	City:	State:	Zip:
Phone No.:			

Secondary

Name:	Relationship:	Emergency Contact: □ Yes □ No	
Street Address:	City:	State:	Zip:
Phone No.:			

PARENT/GUARDIAN INFORMATION

First Parent / Guardian

Name:	DOB:	Relationship:
Lives with Patient: □ Yes □ No □ Other:	Cell Phone No.:	Work Phone No.:
Employer:	Occupation:	Parents are: □ Married □ Separated □ Living Together □ Divorced

Please provide legal custodial/guardianship documentation as appropriate

Second Parent / Guardian

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

Signature of Patient/Parent/Guardian

Date