Christopher Rural Health Planning Corporation

Today's Date:_____ **Patient Registration Form**

PATIENT INFORMATION

Last Name: First Name: Middle:	Date of Birth:	Social Security #:
Street Address:	City: State:	Zip Code:
Mailing Address: ❑Same as above	City: State:	Zip Code:
Home Phone:	Cell Phone:	Email (Used for Patient Portal):
Marital Status:	Primary Care Provider:	Contact Preference: ❑Home ❑Cell ❑Text ❑Email ❑Mail
Employment Status:	Employer Name:	Preferred Language: / Advance Directive: ❑Yes ❑No

As a Federally Qualified Health Center we are required to collect certain information, please complete the following:

Veteran: ❑Yes ❑No	**Gender Identity:** ❑Male ❑Female ❑Transgender Male ❑Transgender Female ❑Other ❑Choose not to disclose	**Sexual Orientation**:❑Straight ❑Lesbian/Gay ❑Bisexual ❑Something else ❑Don't Know ❑Choose not to disclose
Race (Check all that apply): ❑Asian ❑Black ❑Native Hawaiian ❑Other Pacific Islander ❑Indian/Alaskan Native ❑White ❑Unreported/Refuse to report	**Ethnicity:** ❑Hispanic Latino ❑Non-Hispanic Latino ❑Refused to report	**Household Information:** No. in household _____Annual Income:_____ or circle the value closest to your income: $0 $10,000 $20,000 $30,000 $40,000 $50,000+

RESPONSIBLE PARTY INFORMATION (PERSON TO RECEIVE BILLING STATEMENT)

Last Name: ❑Same as patient First Name: Middle:	Date of Birth:	Social Security #:
Mailing Address:	City: State:	Zip Code:
Telephone Number:	Driver's License #:	Relationship to patient:

INSURANCE INFORMATION (PLEASE GIVE PHOTO ID AND INSURANCE CARD(S) TO THE RECEPTIONIST)

Name of Insurance:	Subscriber No:	Group No:
Insured Name: ❑Same as patient Last Name: First Name: Middle:		
Patient relationship to insured:	Date of Birth: Social Security #:	

EMERGENCY CONTACT/NEXT OF KIN (OTHER THAN PARENT OR SPOUSE)

Last Name: First Name: Middle:	Telephone Number:	
Address:	City: State:	Zip Code:
Relationship to patient:		

Christopher Rural Health tries to meet your special needs. Please help us by circling or noting items you would like assistance with:

❑Sign Language/Interpreter ❑Translator/Language:_____ ❑ Financial Assistance ❑Other:_____

Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____