Northern Counties Health Care, Inc.

Patient Registration (Please Print Neatly)

Welcome to the Northern Counties Health Care (NCHC). Please take the time to fill out this form as accurately as possible so we can best address your needs. You will notice that we ask questions about income, race and ethnic background, sexual orientation and gender identity. We do this so we can review the treatment that all patients receive and make sure everyone gets the highest quality of care. The information you provide on this form is confidential and protected by Federal and State law, and cannot be disclosed without your consent except by court order and as described in the HIPAA Notice of Privacy Practices.

Legal Name* First	Middle Initial	Last	
Preferred Name:	**Social Security #:** - -		
Legal Sex (please check one)* [ ] **Female** [ ] **Male** **Most insurance companies require that we bill under the legal name and sex shown on your insurance card.*			
Date of Birth: ***Month Day Year*** / /	**Relationship Status:** [ ] Single [ ]Partnered [ ] Engaged [ ] Married [ ] Civil Union [ ] Separated [ ] Divorced [ ] Widowed [ ] Additional Category (*please specify*):_____		
CONTACT INFORMATION **Your answers to the following questions will help us reach you quickly and discreetly with important information.**			
Mailing Address: City	State	ZIP	
Physical Address (if different from above): City	State	ZIP	
Home Phone: ( ) - **Okay to leave message?** [ ] Yes [ ] No	**Cell Phone:** ( ) - **Okay to leave message?** [ ] Yes [ ] No	**Work Phone:** ( ) - **Okay to leave message?** [ ] Yes [ ] No	**Best number to use:** [ ] Home [ ] Cell [ ] Work
Email Address*			
***Although the chances are low that unsecured e-mail messages between you and NCHC could be intercepted, the risk exists.*			
Preferred method of contact: [ ] Letter [ ] Home Phone [ ] Cell Phone [ ] Work Phone [ ] Text [ ] Email*			
If you are under 19, the Department of Public Health requires that you provide parent/guardian contact information **Parent/Guardian Name:** Best Phone Number Relationship to you			
Emergency Contact Name: Best Phone Number Relationship to you			
Emergency Contact Physical Address: City State ZIP			
Other Primary Care Provider, if any:	**Other Primary Care Provider Address:**		
Other Regular Health Care Provider 1 (i.e. OB/GYN, behavioral health, etc.):	**Other Regular Health Care Provider 1 Address:**		
Other Regular Health Care Provider 2:	**Other Regular Health Care Provider 2 Address:**		
Preferred Pharmacy:	**Location of Pharmacy** (town):		
Do you have a dentist? [ ] Yes [ ] No	**Name of Dentist if yes:**		
PAYMENT AND INSURANCE INFORMATION			
Check if: [ ] Self-Pay [ ] Uninsured	**Would you like a Sliding Fee Scale Application?** [ ] Yes [ ] No		

Name of Primary Medical Insurance Carrier:	
Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____	**Name and Date of Birth of Policy Holder:**
Name of Secondary Medical Insurance Carrier:	
Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____	**Name and Date of Birth of Policy Holder:**
Name of Primary Dental Insurance Carrier:	
Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____	**Name and Date of Birth of Policy Holder:**
Name of Secondary Dental Insurance Carrier:	
Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____	**Name and Date of Birth of Policy Holder:**

Northern Counties Health Care, as a Federally Qualified Health Center, is required by Federal Law to ask for the following information for statistical purposes only. This is reported annually. Individual patient information is not reported nor disclosed. The collection of this information also assists NCHC in applying for additional grant funds to support and expand its services. Thank you for your cooperation.

Primary Language: [ ] English [ ] Español [ ] Français [ ] Other _____	**Translation Needed:** [ ] Yes [ ] No
Employment Status: [ ] Employed [ ] Unemployed [ ] Disabled [ ] Retired [ ] Student	**Occupation if Applicable:**
Race: [ ] White [ ] Asian [ ] Black/African American [ ] American Indian/Alaska Native [ ] Native Hawaiian/Other Pacific Islander [ ] More than One Race [ ] Choose not to disclose	**Ethnicity:** [ ] Hispanic [ ] Non-Hispanic [ ] Choose not to disclose
Sexual Orientation: [ ] Bisexual [ ] Lesbian or gay [ ] Straight (not lesbian or gay) [ ] Something else [ ] Don't know [ ] Choose not to disclose	**Gender Identity:** [ ] Female [ ] Male [ ] Transgender Male/FTM [ ] Transgender Female/MTF [ ] Other [ ] Choose not to disclose
Homeless Status: [ ] Homeless [ ] Not homeless	**Veteran Status:** [ ] Veteran [ ] Non-Veteran
Household Income: $ per [ ] week [ ] month [ ] year [ ] Choose not to disclose	**Number of people this income supports**:
Are you a Migrant Farm Worker? [ ] No [ ] Yes [ ] Choose not to disclose	

ACKNOWLEDGEMENTS

Initial_____ I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at NCHC and reporting of the failure to the federal government.

Initial_____ I hereby give my consent for the staff of the NCHC to render such diagnostic treatment, treatment services, and ongoing care as may be deemed necessary to me or my child up to age 18 or until such guardianship is discontinued.

Initial_____ I request NCHC to provide me and/or my family with medical/dental care and request that NCHC bill my insurance company directly. I authorize release of any medical or other information necessary to process my claims. I also authorize payment of medical benefits to NCHC.

Initial_____ I understand that I am responsible for any deductibles, co-payments, non-covered service, or Sliding Fee Scale. I understand that my failing to do so may result in my being submitted to collections, reported to the credit bureau, and / or terminated from services at NCHC.

Initial_____ I acknowledge that I have received from NCHC the Patient's Bill of Rights and Responsibilities and HIPAA Notice of Privacy Practices.

Patient/Guardian Signature: **Date:** / /

For office use only: [ ] Sliding-Fee Scale Completed [ ] Copy of Insurance Card(s) [ ] Advance Directives [ ] Referred to O&E

Thank you!