Community Health Centers of Greater Dayton

PATIENT INFORMATION REGISTRATION FORM: Complete all sections

PATIENT INFORMATION:

Last name	First Name	MI	Nickname	Social Security #	Birthdate	Sex

BILLING ADDRESS of Patient or Responsibility Party	City	State	Zip

☐ Home Phone ( )	☐ Alternate Phone ( )	☐ Family/Friend Outside Home ( )

E-Mail Address: ☐ No – Requesting Help ☐ **Refused**

RESPONSIBLE PARTY (Required for patients under 18 or whenever the guarantor is not the patient):

Last Name	First name	MI	Social Security #	Birth Date	Relationship

INSURANCE INFORMATION (Please present ALL Insurance Cards and a Picture ID to the receptionist):

Primary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay $	Policy #	Relationship
Secondary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay $	Policy #	Relationship

INFORMATION FOR STATISTICAL REPORTING ONLY:

Please ☑ race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native Are you Latino/Hispanic?
☐ More than One Race ☐ Native Hawaiian / Other Pacific Islander ☐ YES ☐ NO

☑ Preferred language: ☐ English ☐ Spanish ☐ French ☐ Sign Language ☐ German ☐ Russian ☐ Other:_____

☑ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced ☐ Life Partner ☐ Other:_____

☑ If you are a ☐ Veteran ☐ Smoker | ☑ If you are: ☐ Doubling Up ☐ Transitional ☐ Shelter ☐ Street

Occupation: ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐ Decline to answer ☐ Employed (list below what you do)

If employed tell us what you do: _____

What Advanced Directives do you have: ☐ Living Will ☐ Durable Power of Attorney ☐ None ☐ Decline to answer

If Yes, please specify who & their relation to you _____

Legal Guardian: ☐ Yes, Name_____ ☐ None

Health Care Proxy: ☐ Yes, Name_____ ☐ None

For Patients 18 and Older ONLY

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ Something else (please specify):_____ ☐ Don't Know ☐ Decline to answer

For Patients 18 and Older ONLY

Gender Identity - Do you think of yourself as: ☐ Male ☐ Female ☐ Female-to-Male (FTM/Transgender Male/Trans Man)
☐ Male-to-Female (MTF/Transgender Female/Trans Woman) ☐ Genderqueer, neither exclusively male nor female
☐ Other / Additional gender category (please specify) _____ ☐ Decline to answer

Primary Caregiver: ☐ None/Self ☐ Yes If yes, Who: _____ Relationship: _____

I understand that it is my responsibility to provide complete and accurate information on this form. I understand that failure to provide this information may result in my being responsible for full charges.

Patient Name (Printed)	Signature of Patient/Responsible Party	Date