Patient Registration Form

CHRISTIAN COMMUNITY HEALTH CENTER

Patient Information

Patient Information

Last Name:	First Name: M.I.:		Preferred Name/Pronoun (if applicable):
Date of Birth:	Sex/Gender Identity: ❑Male ❑Female ❑Transgender ❑Gender Queer/Non-Conforming ❑Choose to Not Disclose ❑ Other	Sexual Orientation: ❑Lesbian ❑Gay ❑Homosexual ❑ Bisexual ❑ Don't Know ❑Straight/Heterosexual❑Choose to Not Disclose ❑ Other	
Mailing Address:			Apt #
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Marital Status: ❑Single❑Married❑Divorced❑Widowed	Employment Status: ❑Employed ❑Unemployed ❑Retired ❑Student		Employer Name:
Emergency Contact Name:	Emergency Contact Phone #:		Relationship to Patient:
Primary Care Provider:	Preferred Method of Contact: ❑Cell ❑Home ❑Work ❑ Portal		How did you hear about us?

Additional Information & Responsible Party

Additional Patient Information

Email Address:	Would you like to register for our patient portal? ❑Yes ❑ No	
Race (please select): ❑ White ❑ Black or African American ❑Asian ❑ Decline ❑ American Indian or Alaska Native ❑ Other Pacific Islander ❑ Native Hawaiian ❑ Other	Ethnicity (please select): ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline	
Yearly Household Income (please select): ❑ $0 - $9,999 ❑ $10,000 - $19,999 ❑ $20,000 - $29,999 ❑ $30,000 - $39,999 ❑$40,000 & Over	Household Size:	Housing Status: ❑Own ❑ Rent ❑ Homeless ❑ Shelter
Veteran: ❑ Yes ❑ No	Agricultural Worker: ❑ Yes ❑ No	Do you reside in public housing? ❑ Yes ❑ No
Preferred/Primary Language: ❑English ❑Spanish ❑Refuse to Report ❑Other_____	Highest Education Level: ❑Less than 8th Grade ❑Highschool ❑Some College ❑ College Graduate	

Responsible Party – If the patient is a minor (under the age of 18), the parent/guardian will be listed as the guarantor

Last Name:	First Name:	
Phone #:	Date of Birth:	Social Security #:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Insurance Information

Primary Medical Insurance		Secondary Medical Insurance	
Name of Insurance Company:		Name of Insurance Company:	
Policy Holder Name:	Policy Holder Date of Birth:	Policy Holder Name:	Policy Holder Date of Birth:
Policy #:		Policy #:	
Group #:		Group #:	
Relationship to Patient:		Relationship to Patient:	

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. Sliding fee scale discounts are available based on family size and income. Discounts apply only to current, not future services. I further attest that as of the date of my signature below the income source listed constitutes all of my household income, and that the family members listed are solely dependent on that income, or that the explanation provided to verify my income level is truthful. I have read all the information, completed each section and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information including all insurance information.

Today's Date	Signature of Patient or Responsible Party

Revised 7.2019