Community Healthcare Network

Ask us about our center tours!

Patient Registration Form

Legal Last Name	Legal First Name	Chosen Name (if different)

Address	Apt.	City	State	Zip Code

Phone Number:
(Cell) _____ (Home) _____ (Work) _____

Social Security Number	Date of Birth: Month Day Year	Email
- -	/ /	

If you are 17 or younger: Name of Parent or Legal Guardian	Mother's Maiden Name

I am:
- ☐ Single
- ☐ Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Highest grade completed:
- ☐ Less than high school
- ☐ High school graduate/GED
- ☐ Some college
- ☐ College degree or higher

I am a:
- ☐ Full-time student
- ☐ Part-time student
- ☐ Not a student

I work:
- ☐ Full time
- ☐ Part time
- ☐ I don't work
- ☐ Retired

Income:
$ _____
- ☐ Every week
- ☐ Every two weeks
- ☐ Every month
- ☐ Yearly

Number of dependents: ____

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic
- ☐ Would rather not say

Country of Birth:

_____

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Would rather not say

What language do you speak?
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Cantonese
- ☐ Mandarin
- ☐ Bengali
- ☐ Other: _____

My legal sex is (on ID or insurance card):
- ☐ Male
- ☐ Female

How should we refer to you?
- ☐ He
- ☐ She
- ☐ They
- ☐ Not listed: _____

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Trans Man
- ☐ Trans Woman
- ☐ Genderqueer/Gender non-conforming
- ☐ I do not want to answer
- ☐ Not listed: _____

Sex assigned at birth:
- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ I do not want to answer

Sexual Orientation:
- ☐ Lesbian/Gay
- ☐ Straight
- ☐ Bisexual
- ☐ I don't know
- ☐ I don't want to answer
- ☐ Not listed: _____

Have you ever served in the military?

☐ No
☐ Yes, the US Military
☐ Yes, the military in another country

If yes, at this time I am:

☐ Active duty ☐ In the National Guard
☐ In the Reserves ☐ Retired/not enlisted now

How did you hear about this center?

☐ Friend / Family
☐ Flyer
☐ Internet _____
☐ Health insurance plan
☐ School
☐ 311
☐ Social media _____
☐ Other _____

My pharmacy (drug store):

Name: _____

Phone number: _____

Address:_____

If I have an emergency, please call:

Name: _____ Relationship: _____

Phone number: _____

Address:_____

Consent for Medical Treatment

By signing below, I agree that Community Healthcare Network (CHN) medical providers can give me these services:

☐ Medical care and treatment ☐ X-rays ☐ Lab tests ☐ Medications

I also understand that I do not need to get family planning care at CHN in order to get other care at CHN.

_____ _____
Patient Signature Date

_____ _____ _____
Parent or Legal Guardian Signature Relationship Date
(If patient is 17 years old or younger)

Consent to Release of Medical Records

I understand that my health record is private. I agree that it will not be shared with anyone without my written permission, except if it is needed by:

- Any doctor or hospital involved with my health care or treatment
- A person or health company that pays for my health care
- A health company that helps with other activities to support my health care at CHN

I agree that my insurance benefit payments be made directly to Community Healthcare Network.

_____ _____
Patient Signature Date

_____ _____ _____
Parent or Legal Guardian Signature Relationship Date
(If patient is 17 years old or younger)

Patient Bill of Rights Notice and Acknowledgment

I have received the patient handbook, which includes the Patient's Bill of Rights and has information about the available services at Community Healthcare Network.

_____ _____
Patient Signature Date

_____ _____ _____
Parent or Legal Guardian Signature Relationship Date
(If patient is 17 years old or younger)