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| **Registro de Nuevos Pacientes** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Nombre: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | Fecha de Nacimiento: | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Número de Seguro Social: | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| Dirección: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | Pueblo/Ciudad: | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Código postal: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| Teléfono de casa: | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | Teléfono móvil: | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| Dirección de correo electrónico: | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
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| Si es menor de 18 años, ¿quién tiene su custodia? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Madre | | | | | | | | Padre | | | | | | | | | | Ambos padres | | | | | | | | | | | DCF | | | | | | | | | | Tutor legal | | | | |
| Nombre (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ¿Eres estudiante de la Universidad Estatal de Fitchburg? | | | | | | | | | | | | | | | | | | | Sí, vivo en el campus | | | | | | | | | | | | | Sí, vivo fuera del campus | | | | | | | | | | No | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ¿Cómo nos conoció? | | | | | | | | | | remisión | | | | | | | agencia de servicios sociales | | | | | | | | | | | | | | amigo/familiar/vecino | | | | | | | | | | | | |
|  | | | | | | | | | | anuncio | | | | | | | redes sociales | | | | | | | | | | | | | | otros | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Me gustaría recibir servicios en: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Fitchburg CHC - 326 Nichols Rd, Fitchburg | | | | | | | | | | | | | | | | | | | | | Greater Gardner CHC - 175 Connors St, Gardner | | | | | | | | | | | | | | | | | | | | |  |
|  | ACTION CHC - 130 Water St, Fitchburg | | | | | | | | | | | | | | | | | | | | | South Gardner CHC - 529 Timpany Blvd, Gardner | | | | | | | | | | | | | | | | | | | | |  |
|  | Leominster CHC - 165 Mill St, Leominster | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Me gustaría recibir: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Médico | | | | | | | | | | | | | Salud Conductual | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Dental | | | | | | | | | | | | | Optometría | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **Contacto en caso de emergencia** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | Relación: | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Teléfono de casa: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Teléfono móvil: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
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| **Información Sobre Seguros** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Médico** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Principal** | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | ID: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
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|  | | | | | | | Abonado: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | Auto | | |  |
|  | | | | | | | Fecha de nacimiento del abonado | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |  | | | | | | | | |
| **Secundaria** | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | ID: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
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| **Optometría** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | Fecha de nacimiento del abonado | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |  | | | | | | | |
| **Dental** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Principal** | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | ID: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
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|  | | | | | | | Empleador: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Secundaria** | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | ID: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
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| ***He completado este formulario y certifico que soy el paciente o su representante debidamente autorizado.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Firma | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | Fecha | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Nombre impreso | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | Relación | | | | | | | | | |

Como centro de salud comunitario, estamos obligados a recopilar datos cada año sobre los pacientes que atendemos. Su información de identidad personal (nombre y fecha de nacimiento) es altamente confidencial y no se incluirá en los resultados de la encuesta ni se informará a ninguna agencia. (2023)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **¿Cuál es su identidad de género actual? (Por favor, marque aquí):** | | | | | | | | | | | | | |
| Mujer | Hombre | | | | | Hombre transgénero/Hombre transgénero/Masculino transgénero | | | | | | | |
| Otro | Decidió no revelar | | | | | Mujer transgénero/Mujer transgénero/Femenino transgénero | | | | | | | |
|  | | | | | | | | | | | | | |
| **¿Qué sexo se le asignó al nacer en su certificado de nacimiento original? (Por favor, marque aquí):** | | | | | | | | | | | | | |
| Femenino | | Masculino | | |  | | | | | | | | |
|  | | | | | | | | | | | | | |
| **¿Se considera a sí mismo como? (Por favor, haga clic aquí):** | | | | | | | | | | | | | |
| Heterosexual | | | | | Lesbiana, gay o Homosexual | | | | | | | Bisexual | |
| Otra cosa | | | | | Decidió no revelar | | | | | | | No sè | |
|  | | | | | | | | | | | | | |
| **¿Qué raza(s) le representa(n) mejor? (Marque todas las que correspondan)** | | | | | | | | | | | | | |
| Asiático | | Otros isleños del Pacífico | | | | | | | Indio americano/nativo americano o nativo de Alaska | | | | |
| Blanco | | Negro/Afroamericano | | | | | | | Nativo de Hawai | | | No declarado | |
|  | | | | | | | | | | | | | |
| **Qué etnia le representa mejor (marque una):** | | | | | | | | | | | | | |
| Hispano o Latino/a | | | | | No es hispano ni latino/a | | | | | | | Sin declarar/rechazado | |
|  | | | | | | | | | | | | | |
| **¿Es usted veterano?** | |  | | | Sí | | | | | No | |  | |
|  | | | | | | | | | | | | | |
| **¿Qué idioma prefiere?** | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | |
| **¿Cuántos miembros de la familia hay en su casa?** | | | | | | | | | |  | |  | |
|  | | | | | | | | | | | | | |
| **¿Cuáles son sus ingresos?** | | $ | | | | | | Anualmente | | | Mensualmente | | Semanalmente |
|  | | | | | | | | | | | | | |
| **¿Cuál es su situación actual de vivienda?** | | | | | | | | | | | | | |
| Propietario o alquila | | | Albergue para personas sin hogar | | | | | | | Vivienda de apoyo permanente | | | |
| Doble | | | (Vivir con otras personas en una situación que es temporal e inestable) | | | | | | | | | | |
| Vivienda de transición | | | (Alojamiento prolongado, pero temporal, utilizado para la transición desalojo) | | | | | | | | | | |
| Calle | | | (Vivir a la intemperie, en un vehículo, en un campamento, en una vivienda/refugio improvisado o en otros lugares que generalmente no se consideran seguros o aptos para la ocupación humana) | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Es su situación de vivienda:** | | | | | Sección 8 | | | | | Vivienda pública | | No es una vivienda pública | |
|  | | | | | | | | | | | | | |
| **¿Es usted un trabajador inmigrante?** | | | | No | | |  | | | | | | |
|  | | | | Migrante | | | Empleado en los últimos 24 meses, con residencia temporal establecida para el empleo | | | | | | |
|  | | | | Estacional | | | Empleado en los últimos 24 meses, de forma estacional, sin desplazarse de su residencia | | | | | | |