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| **New Patient Registration** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DOB: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Social Security Number: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | Town/City: | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Zip Code: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Phone: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | Cell Phone: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Email Address: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If you are a minor (under 18 years old), who has custody of you? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Mother | | | | | | | Father | | | | | | | | | | Both Parents | | | | | | | DCF | | | | Legal Guardian | | | |
| Name (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | |  | |
| Are you a Fitchburg State University student? | | | | | | | | | | | | | | | Yes, live on campus | | | | | | Yes, live off campus | | | | | | | | | No | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How did you hear about us? | | | | | | | | | referral | | | | | | | social services agency | | | | | friend/family/neighbor | | | | | | | | |  | |
|  | | | | | | | | | advertisement | | | | | | | social media | | | | | other | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I would like to receive services at: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | 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 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| I would like to receive: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | Medical | | | | | | | | | | Behavioral Health | | | | | | | | | | | | | | | | | | |  |
|  | | Dental | | | | | | | | | | Optometry | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Emergency Contact** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Home Phone: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | Cell Phone: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Insurance Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary** | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | ID: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | |  | | | | | | | | | | | | | | | Group #: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | | Subscriber: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | Self | |  |
|  | | | | | | Subscriber DOB: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  | | | | | | | | | | |
| **Secondary** | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | ID: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | |  | | | | | | | | | | | | | | | | Group #: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | | Subscriber: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Self | |  |
|  | | | | | | Subscriber DOB: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  | | | | | | | | | | |
| **Vision** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | ID: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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|  | | | | | | Subscriber: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | Self | |  |
|  | | | | | | Subscriber DOB: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  | | | | | | | | | | |
| **Dental** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary** | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | ID: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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|  | | | | | | Subscriber: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | Self | |  |
|  | | | | | | Subscriber DOB: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  | | | | | | | | | | |
|  | | | | | | Employer: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| **Secondary** | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | ID: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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|  | | | | | | Subscriber: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Self | |  |
|  | | | | | | Subscriber DOB: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***I have completed this form and certify that I am the patient or the duly authorized agent of the patient.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signature | | | | | | | | | | | | | | | | | | | | |  | | | | | | Date | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |  | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Printed Name | | | | | | | | | | | | | | | | | | | | |  | | | | | | Relationship | | | | |

We are required, as a community health center, to collect data each year about the patients we serve. Your personal identity information (name and date of birth) is highly confidential and will not be included in the survey results or reported to any agency. (2023)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **What is your current gender identity? (Please check one):** | | | | | | | | | | | | | |
| Female | Male | | | | | Transgender Male/Transgender Man/Transgender Masculine | | | | | | | |
| Other | Chose not to disclose | | | | | Transgender Female/Transgender Woman/Transgender Feminine | | | | | | | |
|  | | | | | | | | | | | | | |
| **What sex were you assigned at birth on your original birth certificate? (Please check one):** | | | | | | | | | | | | | |
| Female | | Male | | |  | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Do you think of yourself as (Please check one):** | | | | | | | | | | | | | |
| Heterosexual/straight | | | | | Lesbian, gay or Homosexual | | | | | | | Bisexual | |
| Something else | | | | | Chose not to disclose | | | | | | | I don’t know | |
|  | | | | | | | | | | | | | |
| **Which race(s) best represent you? (Check all that apply)** | | | | | | | | | | | | | |
| Asian | | Other Pacific Islander | | | | | | | American Indian/Native American or Alaska Native | | | | |
| White | | Black/African American | | | | | | | Native Hawaiian | | | Unreported | |
|  | | | | | | | | | | | | | |
| **Which ethnicity best represents you (Please check one):** | | | | | | | | | | | | | |
| Hispanic or Latino/a | | | | | Not Hispanic or Latino/a | | | | | | | Unreported/Refused | |
|  | | | | | | | | | | | | | |
| **Are you a Veteran?** | |  | | | Yes | | | | | No | |  | |
|  | | | | | | | | | | | | | |
| **What language do you prefer?** | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | |
| **How many family members are in your household?** | | | | | | | | | |  | |  | |
|  | | | | | | | | | | | | | |
| **What is your income?** | | $ | | | | | | Annually | | | Monthly | | Weekly |
|  | | | | | | | | | | | | | |
| **What is your current housing status?** | | | | | | | | | | | | | |
| Own or rent | | | Homeless Shelter | | | | | | | Permanent Supportive Housing | | | |
| Doubled up | | | (Living with others in a situation that is temporary and unstable) | | | | | | | | | | |
| Transitional Housing | | | (Extended, but temporary, housing used to transition from a homeless environment) | | | | | | | | | | |
| Street | | | (Living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy) | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Is your housing status:** | | | | | Section 8 | | | | | Public Housing | | Not Public Housing | |
|  | | | | | | | | | | | | | |
| **Are you a migrant worker?** | | | | No | | |  | | | | | | |
|  | | | | Migratory | | | Employed in the last 24 months, with temporary residence established for employment | | | | | | |
|  | | | | Seasonal | | | Employed in the last 24 months, on a seasonal basis, without moving away from residence | | | | | | |