Northern Counties
HEALTH CARE
Compassionate Care in Our Home or Yours

Patient Registration
(Please Print Neatly)

Welcome to the Northern Counties Health Care (NCHC). Please take the time to fill out this form as accurately as possible so we can best address your needs. The information you provide on this form is confidential and protected by Federal and State law, and cannot be disclosed without your consent except by court order and as described in the HIPAA Notice of Privacy Practices.

Legal Name* First Middle Initial Last

Preferred Name: | **Social Security #:**

Sex at Birth (please check one)* [ ] **Female** [ ] **Male**
**Most insurance companies require that we bill under the legal name and sex shown on your insurance card.*

Date of Birth:
Month Day Year
/ /

Relationship Status:
[ ] Single [ ] Married [ ] Divorced [ ] Civil Union
[ ] Separated [ ] Widowed [ ] Declined (*please specify*):_____

If you are under 19, the Department of Public Health requires that you provide parent/guardian contact information
Parent/Guardian Name: Date of Birth Best Phone Number Relationship to you

Mailing Address: City State ZIP

Physical Address (if different from above) City State ZIP

Home Phone:
Okay to leave message?
[ ] Yes [ ] No

Cell Phone:
( ) -
Okay to leave message?
[ ] Yes [ ] No

Work Phone:
( ) -
Okay to leave message?
[ ] Yes [ ] No

Best number to use:
[ ] Home [ ] Cell [ ] Work

Email Address*

******Although the chances are low that unsecured e-mail messages between you and NCHC could be intercepted, the risk exists.*

Preferred method of contact: [ ] Letter [ ] Home Phone [ ] Cell Phone [ ] Work Phone [ ] Text [ ] Email*

Emergency Contact Name: Date of Birth Best Phone Number Relationship to you

Other Primary Care Provider, if any: | **Other Primary Care Provider Address:**

Do you have a dentist?
[ ] Yes [ ] No

Name of Dentist if yes:

PAYMENT AND INSURANCE INFORMATION

Name of Primary Medical Insurance Carrier:

Policy Holder: [ ] Patient [ ] Spouse
[ ] Parent [ ] Other_____

Name and Date of Birth of Policy Holder:

Name of Secondary Medical Insurance Carrier:

Policy Holder: [ ] Patient [ ] Spouse
[ ] Parent [ ] Other_____

Name and Date of Birth of Policy Holder:

Name of Primary Dental Insurance Carrier:

Policy Holder: [ ] Patient [ ] Spouse
[ ] Parent [ ] Other_____

Name and Date of Birth of Policy Holder:

Name of Secondary Dental Insurance Carrier:

Policy Holder: [ ] Patient [ ] Spouse
[ ] Parent [ ] Other_____

Name and Date of Birth of Policy Holder:

Check if: [ ] Self-Pay [ ] Uninsured

Would you like a Sliding Fee Scale Application? [ ] Yes [ ] No

Northern Counties Health Care, is a Federally Qualified Health Center. We are required by Federal Law to ask for the following information for statistical purposes only. Thank you for your cooperation.

Primary Language: [ ] English [ ] Español [ ] Français [ ] Other _____	**Translation Needed:** [ ] Yes [ ] No
Race: (SELECT UP TO TWO) [ ] White [ ] Black/African American [ ] Asian [ ] American Indian/Alaska Native [ ] Native Hawaiian [ ] Other Pacific Islander [ ] Choose not to disclose	**Ethnicity:** [ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Choose not to disclose
Sexual Orientation: [ ] Lesbian or gay [ ] Straight (not lesbian or gay) [ ] Bisexual [ ] Something else [ ] Don't know [ ] Choose not to disclose	**Gender Identity:** [ ] Male [ ] Female [ ] Transgender Male/FTM [ ] Transgender Female/MTF [ ] Other [ ] Choose not to disclose
Current Living Status: [ ] I have a steady place to live [ ] I have a place to live today, but I am worried about losing it in the future **[ ]** Homeless	**IF you answered Homeless:** [ ] I am staying in a homeless shelter [ ] I am staying in transitional housing [ ] I am doubling up (temporarily staying with others) [ ] I am living on the street (outside, in a car, abandoned building, in a park) [ ] I am living in permanent supportive housing [ ] Other (hotel/motel) [ ] Unknown
Are you a Veteran of the uniformed services of the United States (Army, Air Force, Coast Guard, Marines, National Guard, Navy)? [ ] Yes [ ] No	
Employment Status: [ ] Child [ ] Employed [ ] Unemployed [ ] Self Employed [ ] Student [ ] Retired [ ] Disabled [ ] Other	**Occupation if Applicable:**
Agricultural Employment [ ] Non-Agricultural [ ] I am a Seasonal Farmworker [ ] I am a Migrant Farmworker [ ] I am a Year-round Farmworker [ ] I am a Retired Farmworker [ ] Choose not to disclose	**Household Income:** $ _____ **/per** [ ] Week [ ] Month [ ] Year **Number of people this income supports**:

ACKNOWLEDGEMENTS

Initial_____ I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at NCHC and reporting of the failure to the federal government.

Initial_____ I hereby give my consent for the staff of the NCHC to render such diagnostic treatment, treatment services, and ongoing care as may be deemed necessary to me or my child up to age 18 or until such guardianship is discontinued.

Initial_____ I request NCHC to provide me and/or my family with medical/dental care and request that NCHC bill my insurance company directly. I authorize release of any medical or other information necessary to process my claims. I also authorize payment of medical benefits to NCHC.

Initial_____ I understand that I am responsible for any deductibles, co-payments, non-covered service, or Sliding Fee Scale. I understand that my failing to do so may result in my being submitted to collections, reported to the credit bureau, and / or terminated from services at NCHC.

Initial_____ I acknowledge that I have received from NCHC the Patient's Bill of Rights and Responsibilities and HIPAA Notice of Privacy Practices.

Patient/Guardian Signature: **Date:** / /

For office use only: [ ] Sliding-Fee Scale Completed [ ] Copy of Insurance Card(s) [ ] Advance Directives [ ] Referred to CRC

Thank you!