Patient Registration

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:	Last:
Preferred Name:		Social Security Number:

Sex Assigned at Birth
*Most insurance companies require that we bill under the legal name and sex shown on your insurance card.

Date of Birth:	Relationship Status:	If other, please specify

CONTACT INFORMATION
Your answers to the following questions will help us reach you quickly and discreetly with important information.

Mailing Address:	City:	State:	Zip:
Physical Address (if different from above):	City:	State:	Zip:

Home Phone:	Mobile Phone: Okay to call? ( ) Yes ( ) No Okay to text? ( ) Yes ( ) No	Work Phone:

Best number to use: ( ) Home ( ) Cell ( ) Work

Email Address* (NOT a family or shared email. Unique to one person).
*Although the chances are low that unsecured e-mail messages between you and NCHC could be intercepted, the risk exists.

Preferred method of contact: ( ) Mail ( ) Home Phone ( ) Mobile Phone ( ) Work Phone ( ) Portal

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:

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:

Preferred Pharmacy

PAYMENT AND INSURANCE INFORMATION

Name of Primary Medical Insurance Carrier:

Policy Holder: Relationship if other:	Name and Date of Birth of Policy Holder:

Name of Secondary Medical Insurance Carrier:

Policy Holder: Relationship if 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:	Translation Needed: ( ) Yes ( ) No
Race:	Ethnicity:
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 ( ) Gender non-conforming ( ) 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:

_____ Initialize	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.
_____ Initialize	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.
_____ Initialize	I hereby give my consent for NCHC staff to retrieve my electronic medication and prescribing history for the purpose of care and treatment.
_____ Initialize	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.
_____ Initialize	I understand that I am responsible for any deductibles, co-payments, non-covered service, or Sliding Fee Scale for any provider visits, in person or via telehealth. 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.
_____ Initialize	I acknowledge that I have received from NCHC the Patient's Bill of Rights and Responsibilities and HIPAA Notice of Privacy Practices.
_____ Initialize	I understand that NCHC does not allow patients to record visits on a smart phone or other device.
_____ Initialize	I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the photographs will be used only to support the medical care provided to me or my child. I understand the pictures taken will be safely and only stored with my or my child's health records. Refusal to consent to photographs is a choice I may make and will not result in a refusal to treat me. If I have any questions or wish to withdraw my consent in the future I may contact the health center front office staff or my provider.
_____ Patient/Guardian Signature	_____ Date: