Holyoke Health Center, Inc.

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Last Name: _____ **First Name:** _____ **MI:** ___

Date of Birth: ___/___/___ **Date:** ___/___/___ **Medical Record #:** _____

REGISTRATION FORM

Welcome to Holyoke Health Center, Inc. We are glad that you have chosen us as your medical home. Please answer the following questions about yourself so that we may be able to serve you. If you need help with any questions please ask.

1. **Preferred Name (if different from legal name) :** _____ _____/_____/_____
   Social Security Number

2. **Sex at birth:** ☐ Male ☐ Female **Health Care Proxy completed?** ☐ Yes ☐ No ☐ N/A

3. **Demographics:**

   _____ _____
   Mailing Street Address Apartment Number

   _____ _____ _____
   City State Zip

   _____ _____ (_____)_____
   Emergency Contact **(Relationship)** **Emergency Contact Phone Number**

   _____ _____ (_____)_____
   Parent / Guardian Printed Name (Relationship) Phone Number

   _____ _____ (_____)_____
   Parent / Guardian Printed Name (Relationship) Phone Number

   _____ _____ ☐ Full Time ☐ Part Time ☐ Other (specify): _____
   Employer Name Occupation

   _____ ☐ Full Time ☐ Part Time ☐ Other (specify): _____
   School Name

4. **Contact Methods:** (It is important for us to have an active phone number for you so that we are able to contact you regarding appointments and anything pertinent to your health)

		Best Contact Method	**Ok to leave a confidential message**	
a.	Daytime Phone: (_____)_____	☐	☐ Yes	☐ No
b.	Home Phone: (_____)_____	☐	☐ Yes	☐ No
c.	Cell Phone: (_____)_____	☐	☐ Yes	☐ No

   (Cell phone numbers are an automatic OPT-IN for appointment reminders, notify the front desk if you would like to OPT-OUT of this option)

   d. Email Address: _____

5. **Insurance Information**
   Please inform the Front Desk staff if this visit is related to an Auto Accident, Workers Compensation, or Disability Claim

   Primary Insurance: _____ Policy#: _____
   Grp#: _____ Ins. Phone#: _____
   Insurance Address: _____
   Policy Holder's Name: _____ Relationship to Patient: _____
   Policy Holder's Birthdate: _____

*** If there is No** Secondary **Insurance, please circle: NONE**

Secondary Insurance: _____ Policy#: _____
Grp#: _____ Ins. Phone#: _____
Insurance Address: _____
Policy Holder's Name: _____ Relationship to Patient: _____
Policy Holder's Birthdate: _____

I have presented evidence of valid insurance coverage, as of this date below to Holyoke Health.
I understand that I am financially responsible for all charges incurred for services provided.
I understand that payment is due at the time of services are rendered.

In order to serve you better, please answer the following questions.
(The information you give will be kept confidential and private. Information you share will not impact your eligibility for assistance, housing or other programs. You can still get services if you choose not to provide the following information).

6. What is your current housing/homeless status?
- ☐ At a Shelter
- ☐ Doubling Up with a friend/family member
- ☐ In Transitional Housing
- ☐ On the Street
- ☐ Not Homeless
- ☐ Decline to Specify

7. What is your preferred spoken language? _____

8. What is your preferred written language? _____

9. Gender: (You do not have to answer for children under the age of 13)
- ☐ Male
- ☐ Female
- ☐ Transgender Male ⇨ Female
- ☐ Transgender Female ⇨ Male
- ☐ Gender Queer
- ☐ Choose not to disclose
- ☐ Other: _____

10. Sexual Orientation: (You do not have to answer for children under the age of 13)
- ☐ Straight (not lesbian or gay)
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Choose not to disclose
- ☐ Don't Know
- ☐ Something else: _____

11. What race(s) do you identify as?
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Decline to specify

12. What ethnicity do you identify as?
- ☐ Hispanic/ Latino
- ☐ Non-Hispanic/ Latino
- ☐ Decline to specify

13. What is your household's total annual income? _____

14. How many people are in your household, including yourself? _____

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15. Have you ever served in the military? ☐ Yes ☐ No

16. Consent for Care/Treatment:

I hereby authorize the staff and supervised health professional students, of Holyoke Health Center, Inc. (HHC) to render such services as may be deemed necessary to me. I have read and understand my rights and responsibilities and I assign HHC authority to claim and collect medical insurance benefits and payments on my behalf. I understand that I am responsible for paying for my care if my insurance does not pay for it.

Signature: _____ Date: _____/_____/_____

In case of a minor child, signature is of: ☐ *Parent* ☐ *Legal Guardian* ☐ *Emancipated Minor* ☐ *Power of Attorney*

17. Notice of Privacy Practices:

I understand that Holyoke Health Center, Inc. (HHC) will use my health information for treatment, payment and healthcare operations. I have been given a copy of HHC's 'Notice of Privacy Practices', which provides a complete description of how my health information will be used. I understand that the organization reserves the right to change their notice and practices, and that I have the right to obtain a revised notice.

Signature: _____ Date: _____/_____/_____

In case of a minor child, signature is of: ☐ *Parent* ☐ *Legal Guardian* ☐ *Emancipated Minor* ☐ *Power of Attorney*

18. Process for Complaints and Grievances:

I understand that Holyoke Health Center, Inc. (HHC) wants to provide me with the best care possible. In the event that I am unhappy with services provided to me, I will let my provider know. I have been given a document describing how to file a complaint or grievance regarding any of the services I've received from the Holyoke Health Center, Inc.

Signature: _____ Date: _____/_____/_____

In case of a minor child, signature is of: ☐ *Parent* ☐ *Legal Guardian* ☐ *Emancipated Minor* ☐ *Power of Attorney*

19. Additional person(s) authorized to make the use or disclosure PHI:
(Uses and disclosures may be permitted without prior consent in an emergency and according to our Notice of Privacy Practices.)

Holyoke Health Center, Inc. (HHC) values and does everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children or any significant others without your written consent). If you would like for HHC to communicate with anyone other than yourself by phone, in person and may accompany any children into the office please list their name, date of birth and relationship below. A separate release of information is needed for anything other than communication with the following persons or anyone other than those listed. This includes any and all confidential information.

☐ **At this time I do not want to authorize anyone** (For children both parents will automatically have authorization unless court documents are presented stating one is not authorized.)

☐ **I, the undersigned, hereby authorize HHC staff to communicate with the following individual(s)**

a. Name: _____ Date of birth: _____ Relationship: _____

b. Name: _____ Date of birth: _____ Relationship: _____

Signature: _____ Date: _____/_____/_____

In case of a minor child, signature is of: ☐ *Parent* ☐ *Legal Guardian* ☐ *Emancipated Minor* ☐ *Power of Attorney*

HHC Staff: _____