Chiricahua Community Health Centers, Inc.
Adult Registration Form

Today's Date: _____

Last Name	First Name	M.I.	Birth Date:
Social Security#	Other names you may go by:		

Street Address	City	State	Zip
Mailing Address	City	State	Zip
Home phone:		Message phone	Other?
Employer	Address	City	Work Phone:

If the patient has a court appointed legal guardian, list this person's name below.

Guardian	Relationship & Phone#
Address (if different)	Date of Birth:

In case of emergency, contact:

Name	Telephone	Relationship

Please complete the following:

	Male
	Woman

Marital Status

	Single
	Married
	Divorced
	Living together
	Separated
	Widowed

Ethnicity

	African American
	Asian
	Hispanic / Latino
	Native American
	White / Caucasian
	Other (Specify):

Language Spoken:

	English
	Spanish
	Other language?

US Citizenship:

	Yes
	No

Would you like Living will and Medical Powers of Attorney information? __Yes __ No

If you already have a Living Will, Medical Power of Attorney, DNR or other Health Care Directive, please present it to us, so we may make a copy.

I, _____ hereby give Chiricahua Community Health Centers, Inc. my consent to give treatment to the above named patient.

_____ _____

Signature of patient or legal guardian Date

These statements made by me or on my behalf are true to the best of my knowledge. I authorize this provider to verify any information given. I have been informed of my rights and responsibilities regarding eligibility for services. I hereby authorize the provider at Chiricahua Community Health Centers, Inc. to examine and treat me and to perform any diagnostic or lab tests as necessary. I understand that there is a chance for error with any diagnostic or lab test performed. I understand that if tests are taken for sexually transmitted diseases reporting of certain positive results to public health agencies is required by law.

I further understand that referral will be made for further diagnosis or treatment if needed and that I am responsible for obtaining such follow-up. I hereby give my permission for reviewing agencies and billing authorities to have access to my medical records for statistical gathering, reimbursements or medical costs, review of quality of care and federal system reviews with the understanding that confidentially will be maintained.

_____ _____

Signature of patient or legal guardian Date