

Chiricahua Community Health Centers, Inc.

Patient – CHILD – Registration Form

Today's Date: _____

Last Name		First Name	
Birth Date:		Social Security #	
Street Address	City	State	Zip
Mailing Address	City	State	Zip
Home phone:		Message phone	Other?
Employer	Address	City	Work Phone:

If patient is a child, list Parents names, dates of Birth and SS#:

Mother's Name		Father's Name:	
Date of Birth:	SS #	Date of Birth:	SS #

Please complete the following:

<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> English	<input type="checkbox"/> Citizenship
<input type="checkbox"/> Woman	<input type="checkbox"/> Married	<input type="checkbox"/> Spanish	<input type="checkbox"/> US (Yes)
<input type="checkbox"/> White	<input type="checkbox"/> Divorced	<input type="checkbox"/> Other language?	<input type="checkbox"/> US (No)
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Living together	List other names you may go by:	
<input type="checkbox"/> Other	<input type="checkbox"/> Separated	<input type="checkbox"/> Farm/Agriculture Worker	
<input type="checkbox"/>	<input type="checkbox"/> Widowed		
<input type="checkbox"/>	<input type="checkbox"/> Child		

In case of emergency contact:

Name	Telephone	Relationship
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Would you like to receive information regarding Living will and Medical Powers of Attorney? ___ 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 _____ myself _____ my minor child.

_____ Date _____

Signature of patient or parent / legal guardian

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.

_____ Date _____

Signature of patient or parent / legal guardian