Welcome to Lowell Community Health Center
Adult Patient Registration Form

Medical Record Number

## I. Patient General Information

Last Name: _____ First Name _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: ☐ Married ☐ Divorced ☐ Partner ☐ Separated ☐ Single ☐ Widow

Home Phone Number: _____ Ok to Call? ☐ Yes ☐ No Cell Phone Number: _____ Ok to Call? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose not to disclose

Sexual Orientation: ☐ Lesbian or gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

## II. Employment Information

Are you employed? ☐ Yes ☐ No Student Status: ☐ Full Time ☐ Not a Student ☐ Part Time

Employment Status (check one) ☐ Full Time ☐ Migrant Worker ☐ Seasonal Worker ☐ Part Time ☐ Self-Employed ☐ Retired

## III. Emergency Contact

Emergency Contact Name: _____ Emergency Phone Number: _____

Relationship to Patient: _____ Other Phone Number (Cell, Pager, Etc.): _____

## IV. Family Size & Income and Insurance Information

(Please include yourself, spouse, children under the age of 18, and if pregnant, the number of children you are expecting)
Number of persons in your household: _____ Weekly Family Gross Income: _____

**Do you have health coverage? (Check one)** ☐ **Yes** ☐ **No** If you answered NO, would you like to speak to a financial counselor to apply for assistance? ☐ Yes ☐ No

Primary Insurance Name: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscribers Name: _____ Subscriber DOB: _____
Insurance Policy Number: _____ Group Number: _____

## V. Additional Information/Structured

Would you like to join the patient portal? ☐ Yes ☐ No Email Address: _____

Race/How do you describe yourself? (Check all that apply)

☐ Asian ☐ Black/African American ☐ American Indian or Alaskan Native ☐ White

☐ More than one race ☐ Pacific Islander ☐ Prefer not to disclose ☐ Native Hawaiian

Are you Hispanic/Latino? ☐ Yes ☐ No

What language do you feel most comfortable speaking to your provider in? _____ Do you need an interpreter/translator? ☐ Yes ☐ No

Housing Status/Characteristics: ☐ Doubling Up ☐ Homeless ☐ Transitional ☐ Street ☐ Unknown ☐ Public Housing ☐ Other _____

Are you a veteran of the U.S. armed forces? ☐ Yes ☐ No

What is your ethnicity/ancestry? (Check One Box) In what country were you born? _____

☐ African ☐ American ☐ Cambodian ☐ Colombian ☐ Dominican ☐ Portuguese ☐ Puerto Rican ☐ Other _____

Pharmacy Name: _____ Address: _____

Do you currently have a dentist? ☐ Yes ☐ No Dentist Name: _____ Address: _____

## Lowell Community Health Center Consent

**Patient Name:** _____ **Medical Record Number:**_____

**Date of Birth:** _____

**(I) Consent to Treat:**

I hereby authorize Lowell Community Health Center and all its included departments to render any health services and treatment that is deemed necessary, to me in accordance with the policies and procedures of the Health Center. I understand that I retain the right to refuse any or all of the recommended treatment.

**(II) Consent to Share Medical Records:**

I understand that my medical record information could be shared within the different departments of the Lowell Community Health Center. The information will be shared only to help in my health care assessment and management.

At the present time the departments under Lowell Community Health Center include Access Department/Adult Medicine/Behavioral Health and Integrative Services/CARIÑO HIV Services/Family Medicine/Family Planning/ Metta Health Center/OB-Gyn/Pediatric Medicine and School Based Health Centers. Additional departments may be added in the future.

I also understand that at any time during the course of my medical treatment, if a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist as necessary for medical care.

I hereby authorize Lowell Community Health Center to release my medical records to be reviewed for the purposes of an Audit and/or Evaluation. (The purpose of this review is to enhance patient care and to comply with managed care requirements). I understand that no identification of my name or address will be recorded during this review process.

**(III) Health Information Privacy:**

I understand that the Lowell Community Health Center adopts a very strict policy regarding confidentiality of my medical treatment and follows the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule which permits the health center to use and disclose Protected Health Information, with certain limits and protection, for treatment, payment and health care operations.

**(IV) Medical Insurance Authorization and Assignment:**

I hereby authorize Lowell Community Health Center and all its included entities to furnish information to my insurance carriers concerning my illness and treatments. I hereby also assign to the Provider(s) and/or Lowell Community Health Center, all the payments for the medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

**By signing below I understand that this consent in its entirety will remain in effect as long as I continue to receive health care services at Lowell Community Health Center.**

_____ I have received the Notice of Privacy Practices (Confidentiality Statement), Patient Responsibilities and Consumer Bill of Rights.

_____ Health Proxy offered

_____ _____

Signature of the Patient Date

_____ _____

Signature of Parent/Guardian
(If patient is a minor)

Signature of Witness