Holyoke Health Center, Inc.

Affix label here

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 and your family so that we may be able to serve you. If you need help with any questions please ask and we will be glad to help you.

1. **Preferred Name (if different from legal name) :** _____ _____/_____/_____
   Social Security Number
2. **Health Care Proxy completed?** ☐ Yes ☐ No ☐ N/A
3. **Sex at birth:** ☐ Male ☐ Female
4. **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

5. **Contact Methods:**

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

d. **Email Address:** _____

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? _____

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

Holyoke Health Center, Inc.

Affix label here

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

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

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. 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: _____