Bluegrass Community Health Center

PATIENT REGISTRATION FORM

Patient First Name:	**Last Name**	**Middle**	
Date of Birth:		**Social Security Number:**	
Home Address:	**City**	**State**	**Zip Code**
Home Phone:		**Cell Phone:**	
Email:			
Preferred Method of Contact: *(check one)* ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ None			
Emergency Contact Name:	**Relationship:**	**Phone:**	

If patient is under 18 years of age, please add parents' / guardians' information

Name 1:	**Relationship to patient:**	**Date of Birth:**	**Social Security Number:**
Address *if different than patient address*		**Phone Number:**	
Name 1:	**Relationship to patient:**	**Date of Birth:**	**Social Security Number:**
Address *if different than patient address*		**Phone Number:**	

Additional Patient Information

Gender Assigned at Birth:
☐ Male
☐ Female

Gender:
☐ Male
☐ Female
☐ Female-to-Male/Transgender Male/Trans
☐ Male-to-Female/Transgender Female/Trans Woman
☐ Neither exclusively Male nor Female
☐ Other _____

Sexual Orientation:
☐ Straight or Heterosexual
☐ Lesbian, Gay, or Homosexual
☐ Bisexual
☐ Choose not to disclose
☐ Other _____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic
☐ Unknown
☐ Choose not to disclose

Race:
☐ Alaskan Native
☐ American Indian
☐ Asian
☐ Black/African American
☐ Hawaiian Native
☐ Middle Eastern
☐ Pacific Islander
☐ White
☐ More than one race
☐ Unknown
☐ Choose not to disclose

Primary Language:
☐ English
☐ Spanish
☐ Other _____

Interpreter Needed:
☐ Yes ☐ No

Marital Status:
☐ Domestic Partner ☐ Separated
☐ Single ☐ Widowed
☐ Divorced ☐ Married

Veteran Status:
Are you a veteran?
☐ Yes ☐ No

Preferred Pharmacy:
Mail Order
Pharmacy Name:_____ **Address:**_____

Local
Pharmacy Name:_____ **Address:**_____

Note: As a Federally Qualified Health Center, Bluegrass Community Health Center (BCHC), is required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists BCHC in applying for additional grant funds to support and expand services. Thank you for your cooperation.

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Household and Income Information:

How many people live in your home and share income?_____

What is the approximate total monthly income for the people in your home? _____

Housing Status:

☐ Own / Rent ☐ No permanent housing Do you live in Public Housing: ☐ Yes ☐ No

If you checked "No Permanent Housing" where are you currently staying?

☐ Doubling up (staying with Family / Friends ☐ Shelter ☐ Street/Car ☐ Transitional ☐ Other: _____

Agriculture Information:

☐ Yes ☐ No In the last two years, have you or a member of your family worked in the fields, orchards, greenhouses, farms, horse farms, vineyards, packing houses, or with animals such as cattle, dairy, sheep, poultry, fish, hatcheries, etc.?

☐ Yes ☐ No In the last two years, have you or your family moved to another area to work in the fields, orchards, greenhouses, farms, horse farms, vineyards, packing houses, or with animals such as cattle, dairy, sheep, poultry, fish, hatcheries, etc.?

Insurance Information - Please present your card (s) to front office staff

Type of Primary Coverage: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Other:_____

☐ None ***Your household income and family size may qualify you and your family for BCHC's Sliding Fee Discount Program. If you are interested in applying, please complete the Sliding Fee Discount Application.***

Type of Secondary Coverage: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Other:_____

Responsible Party

Relationship to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____

Full Legal Name:	Date of Birth:	Social Security Number:

Mailing Address: ☐ *same as home* City State Zip Code

Home Phone:	Cell Phone:	Work Phone:

Healthcare Arrangements

An advance directive tells your doctors and other health care workers what types of care you would like to have if you become unable to make medical decisions.

Do you have an advance directive? ☐ Yes ☐ No

Would you like information about advance directives? ☐ Yes ☐ No

I certify that the information on this form is complete and correct:

Patient Signature:_____ Date:_____

If patient is under 18 years of age, responsible party/guarantor signature

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