WESTCHESTER COMMUNITY HEALTH CENTER

☐ Westchester Community Health Center Mount Vernon ☐ Westchester Community Health Center Greenburgh ☐ Westchester Community Health Center Yonkers
☐ Westchester Community Health Center Lake Street ☐ Mobile Health Mobile

Patient Registration Form

As a Federally Qualified Health Center, Westchester Community Health Center is required to collect patient demographic information. This information will be used to assist in the coordination of your care, collect payments and improve our ability to serve you better. The information you provided is confidential.

Thank you for choosing Westchester Community Health Center for your healthcare needs.

PATIENT INFORMATION

First Name	Middle Name	Last Name	Suffix

Social Security Number	Gender		Date of Birth	Marital Status		
	☐Male	☐Female		☐Single	☐Married	☐Other

City and State of birth:	Country of Birth:
Street Address	City

State	Zip Code	Email	Primary Phone		
		OK To Email: ☐ Yes ☐ No	☐Home	☐Cell	☐Work

Home Phone		Cell Phone		Work Phone	

H: OK To Leave Message ☐ Yes ☐ No	C: OK To Text: ☐ Yes ☐ No	C: OK To Leave Message: ☐ Yes ☐ No	
How Did you Learn About Us?	☐Friend ☐Family Referral	☐Physician Referral	☐Social Media
☐Online ☐TV Advertisement	☐Newspaper Advertisement	☐Radio Advertisement	☐ WCHC Website
☐WCHC Facilitated Enrollment Dept	☐Outreach Dept	☐Other:	

Primary Language	☐English	☐Spanish
	☐Sign Language	☐Other:

What is the annual gross income of your family? $ **What is the total number of people in the household?**

What is your source of income?

Please list the names of your children living in your household under the age of 18 years old

Name (Last, First)	Gender	Date of Birth	City and State of Birth	Country of Birth

This health center is a Health center Program grantee under 42 U.S.C 254b and deemed Public Health service Employee under 42 U.S.C 233 (g) – (n)

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Parent/ Guardian Information – Please complete if patient is under 18 years of age				Responsible Party
Mother's Name	**DOB**	**Primary Phone Number**	**Primary Address**	☐
Father's Name	**DOB**	**Primary Phone Number**	**Primary Address**	☐
Guardian's Name	**DOB**	**Primary Phone Number**	**Primary Address**	☐

Race		Ethnicity
☐African American/Black	☐Caucasian/White	☐Latino/Hispanic
☐American Indian or Alaskan Native	☐Native Hawaiian or Other Pacific Islander	☐Non-Latino/Hispanic
☐Asian	☐Other:	☐Chose Not To Disclose/Refused
☐More Than One Race	☐Chose Not To Disclose/Refused	☐Other:

DISABILITY AND SHELTER VERIFICATION

Disabled	Yes	No	Homeless Status		Working Status		
			☐Not Homeless	☐Homeless Shelter	☐Migrant	☐Not Migrant	
			☐Transitional	☐Doubling Up	☐Seasonal		
			☐Street ☐ Refused	☐ Permanent Supportive Housing ☐Other_____	Veteran	☐Yes	☐No

EMERGENCY CONTACT

Patient's Relation to Emergency Contact	☐Child	☐Parent	☐Spouse	☐Other:

First Name	Middle Name	Last Name	Suffix

Street Address	City

State:	Zip Code:		Primary Phone		
			☐Home	☐Cell	☐Work
Home Phone		**Cell Phone**		**Work Phone**	

Do you require translation services in a language other than English? ☐ Yes ☐ No

If yes, what is your preferred language?

Are you hearing impaired? ☐ Yes ☐ No

If yes, do you need sign language interpreter services? ☐ Yes ☐ No

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Are you disabled or requires any type of assistance not stated above? ☐ Yes ☐ No
If yes, please explain:
Do you have Health insurance? ☐ Yes ☐ No
Would you like to apply for health insurance? ☐ Yes ☐ No
Do you have an Advance Directive / Living will? ☐ Yes ☐ No (If yes, please provide a copy for our record.)
Do you have a Primary Care Doctor or Primary Care Dentist? ☐ Yes ☐ No
***If yes, write the name of your Primary Care Doctor: Telephone Number:**
Primary Care Dentist: Telephone Number:
If no, would you like the health center to be your Primary Care Doctor or Primary Care Dentist? ☐ Yes ☐ No
Name of preferred pharmacy: Pharmacy phone number:
Private or Medicare Insurance information (Only)
Insurance Company Name:
Policy / ID Number: Telephone Number:
Subscriber Name: Subscriber DOB:

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that my signature below also confirms that I have received a copy of Westchester Community Health Center Services Privacy Practices, Patient Bill of Rights and Patient Responsibilities.

PATIENT/GUARANTOR SIGNATURE

I _____, attest that the information provided on this form is true and accurate to the best of my ability.

Patient / Guardian Signature_____ Date: _____

Relationship to Patient: _____ Date: _____

Office use only:

Registrar Full Name: _____

Registrar Signature: _____

Date completed: _____

Sliding Fee: _____

Refusal Reason: _____

_____