Harrington Family Health Center

REGISTRATION FORM
(Please Print)

CURRENT PATIENT INFORMATION				
Last Name:	First Name:	Middle Name:	Preferred Name:	
Street Address:		City	State	Zip
PO Box or Mailing Address		City	State	Zip
Home Phone: Primary ❑ Yes ❑ No	Cell Phone: Primary ❑ Yes ❑ No	Work Phone:	Consent to: ❑ Call ❑ Text	
Would you like to sign up for the Patient Portal? ❑ Yes ❑ No If yes, please list email:				
Date of Birth:	Marital Status:	Social Security #:	Gender:	Primary Provider:
Parent(s) or Legal Guardian(s) (if minor):				
Emergency Contact #1:	Relationship to Patient:	Home Phone:	Cell Phone:	
Emergency Contact #2:	Relationship to Patient:	Phone Number:		
Guarantor Name:	Guarantor Address:		Guarantor Phone:	
Relationship to Patient:	Social Security #:	Date of Birth:		

MEDICAL INSURANCE INFORMATION			
Primary Medical Insurance Name	Policy #	Group #	Employer Name
Policy Holder Name/Address (if other than self)	Policy Holder DOB	Relationship to Policy Holder	
Secondary Medical Insurance Name	Policy #	Group #	Employer Name
Policy Holder Name/Address (if other than self)	Policy Holder DOB	Relationship to Policy Holder	
Tertiary Insurance Name	Policy #	Group #	Employer Name
Policy Holder Name/Address (if other than self)	Policy Holder DOB	Relationship to Policy Holder	

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DENTAL INSURANCE INFORMATION			
Please fill in this information if you have Dental Insurance. If not, proceed to the next section			
Primary Dental Insurance Name	Policy #	Group #	Employer Name
Policy Holder Name/Address (if other than self)	Policy Holder DOB	Relationship to Policy Holder	
Secondary Dental Insurance Name	Policy #	Group #	Employer Name
Policy Holder Name/Address (if other than self)	Policy Holder DOB	Relationship to Policy Holder	

REQUIRED REPORTING INFORMATION	
Language	❑ English ❑ Spanish ❑ Patient Declined ❑ Other:
Race	❑ Asian ❑ Black/African American ❑ White ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Declined / Refused ❑ American Indian/Alaska Native ❑ More than one race (specify) _____ _____
Ethnicity	❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Patient Declined
Sexual Orientation	❑ Heterosexual (Straight) ❑ Bisexual ❑ Lesbian, gay or homosexual ❑ Something Else ❑ Don't Know ❑ Choose not to disclose
Gender Identity	❑ Male ❑ Female ❑ Choose not to disclose ❑ Other
Assigned Sex at Birth	❑ Male ❑ Female ❑ Choose not to disclose ❑ Unknown
Pronouns	❑ He/him ❑ She/her ❑ They/them ❑ Declined
Agricultural Worker	❑ N/A ❑ Migrant ❑ Seasonal ❑ Patient Declined
Annual Income	❑ Under $10,830 ❑ $10,831-$33,075 ❑ $33,076-$44,101 ❑ $44,101 and above ❑ Declined
Homeless Status	❑ No ❑ Declined ❑ Transitional ❑ Doubling Up ❑ Homeless Shelter ❑ Street ❑ Other ❑ Unknown

Family Size	____ ❑ Declined	**Homebound?**	❑ Yes ❑ No	**Veteran Status**	❑ Yes ❑ No ❑ Declined
School-based Health Center Patient	❑ Yes ❑ No ❑ Declined	**Public Housing Patient**	❑ Yes ❑ No ❑ Declined		

RELEASE OF INFORMATION / CONSENT FOR TREATMENT

I request that payment for authorized insurance benefits be made to me, or on my behalf, to Harrington Family Health Center for any services furnished to me by that Provider. I authorize any holder of medical information for me to release to my insurance company and its agents any information needed to determine these benefits are payable for related services. I also give permission for the Provider of Harrington Family Health Center to render diagnostic procedures, minor surgical procedures, or medical, dental, or mental health treatment to me/my child. I understand that I am financially responsible to Harrington Family Health Center for any charges not covered by my Health Insurance.

Patient/Parent/Guardian Signature: Date: