NEW PATIENT REGISTRATION FORM
CVHS ACCT: _____

PATIENT INFORMATION				
Last Name, Suffix:	First Name:	Middle Initial:	Preferred Name:	
Mailing Address:				
Street Address (if different from mailing address):	City:	State:	Zip Code:	
Home Phone:	Cell Phone:	Work Phone:		
Date of Birth: ____/____/_____	Sex:	Social Security:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated ☐ Partner	
Gender Identity: ☐ Male ☐ Female ☐ Transgender male (female to male) ☐ Transgender female (male to female) ☐ Other ☐ Choose not to disclose		Sexual Orientation: ☐ Straight or heterosexual ☐ Bisexual ☐ Lesbian, gay, or homosexual ☐ Don't know ☐ Choose not to disclose ☐ Something else		

RESPONSIBLE PARTY (GUARANTOR) ☐ Self (if self, leave blank) ☐ Parent/Legal Guardian ☐ Spouse			
First Name:	Middle Initial:	Last Name, Suffix:	
Mailing Address:	City:	State:	Zip Code:
Guarantor's Date of Birth:	Guarantor's Social Security:	Guarantor's Sex:	Guarantor's Phone Number:
Is Guarantor a patient at CVHS? ☐ Yes ☐ No			
Emergency Contact:	HIPAA: (Circle one) Yes or No		
Relationship:	Telephone Number:		

EMPLOYER INFORMATION	
Employer Name:	Employer Address:

INSURANCE INFORMATION		
Name of primary medical insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Name of secondary insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Name of dental insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify _____		

Preferred Pharmacy:	Location:

DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

The government HIPAA regulations require permission from the patient in order for any healthcare professional to speak with family, friends or caregivers regarding your protected health information, except in cases of emergency.

Please list your choice of individuals for us to disclose/discuss your private health information. Please list those you authorize (i.e.: spouse, children, sibling or caregiver) and remember that even your spouse needs to be listed if it is okay for us to speak with them.

Name:	DOB: ____/____/_____	Phone:	HIPAA: (Circle one) Yes or No

Mailing Address:	City	State:	Zip Code:

Tell us the best way to contact you for appointment reminders, messages, etc.:
☐ Home ☐ Cell ☐ Text Message ☐ Email
Home ☐ Brief (no clinical information) ☐ Extended (some clinical information)
Cell ☐ Brief (no clinical information) ☐ Extended (some clinical information)

Patient's email address:

DEMOGRAPHIC INFORMATION

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Other Pacific Islander ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian ☐ Alaska Native ☐ Other Race ☐ Unreported/Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to report

Language: ☐ English ☐ Spanish ☐ Other

Translator: ☐ Yes ☐ No

Are you a veteran?: ☐ Yes ☐ No
Are you migrant?: ☐ Yes ☐ No
Are you limited in English Proficiency?: ☐ Yes ☐ No
Did you hear about us on Facebook? ☐ Yes ☐ No
Are you a seasonal worker?: ☐ Yes ☐ No
Are you homeless?: ☐ Yes ☐ No
Are you in Public Housing?: ☐ Yes ☐ No

Please read the items below and initial beside each item, then sign and date as noted.	**Initial**
CONSENT TO TREATMENT: I consent for treatment for myself and/or my child for medical/behavioral health/dental services.	
PRIVACY PRACTICE: I have read and understand the CVHS "Notice of Privacy Practices"	
COLLECTIONS POLICY: I have read and understand the CVHS "Collection Policy"	
INSURANCE: I authorize CVHS to furnish information to my insurance company regarding my medical, dental, and behavioral health care. I assign CVHS to receive payment from insurance claims filed by CVHS for medical/dental/behavioral health services. I understand that I am responsible for the payment of all fees. I also understand that I am ultimately responsible for making sure my insurance will cover appointments with CVHS and with specialists to who I am referred to by CVHS providers.	

Please have your insurance card available at check in.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____