Norwalk Community Health Center

Patient Registration Form

Date: _____________

Patient Information					
Last Name		First Name		Middle Inital	
Date of Birth		Social Security Number	_______-_______-_______	Primary Language	
Address				Apartment/ Unit #	
City		State		Zip Code	
Mailing Address (if different)				Apartment/ Unit #r	
City		State		Zip Code	
Email Address		Home Phone		Cell Phone	
Gender at Birth: ☐Male ☐Female ☐Decline to answer		Sex: ☐ Male ☐ Female ☐ Transgender Male/Trans Man/ (FTM) ☐ Transgender Female/ Trans Women/ (MTF) ☐ Genderqueer ☐Decline to Answer ☐Additional Identity:-______________			
Parent or Legal Guardian	Last Name: First Name: Initial:				
Guardian Relationship	☐ Father ☐ Mother ☐ Foster Parent ☐ Grandparent ☐Legal Guardian ☐ Conservator ☐ Power of Attorney ☐ Other______________________________				
Race (Please check all apply)	☐Black or African American ☐ Asian ☐Multiracial ☐Caucasian ☐American Indian/ Alaska Native/ Inuit ☐Pacific Islander ☐ Other				
Ethnicity	☐ Latino ☐Hispanic ☐ Not Latino/Hispanic		US Veteran Status	☐Veteran ☐ Not a Veteran	
Marital Status	☐ Single ☐ Married ☐ Partner ☐Separated ☐ Divorced ☐ Widow				
Housing Status	☐ Living in shelter ☐Living with friend or relative ☐Street ☐Private Housing ☐Public Housing ☐Transitional Living				

Emergency Contact						
Name			Relationship			
Home Phone		Cell Phone		Does this person know you are a patient	☐ Yes	☐ No

Pharmacy Information		
Pharmacy Name		Number
Address		

Financial Information *(For Office Use Only)*				
Approximate Total Household Income	$	☐Yearly ☐Monthly ☐Weekly ☐BiWeekly		
Number of Dependents		Number of individuals under the age of 18 the patient is responsible for including spouse		

Primary Insurance *(you will be asked to show your card at the appointment)*

Name of Policy Holder ____Relationship __________________________

Policy Holder Date of Birth _____________________________________Social Security Number ________________

Name of Primary Insurance_____________________________________Policy Start Date: ______________________.

Policy/ID Number_________________________________Group/Plan Number ________________________________

Secondary Insurance – if applies *(you will be asked to show your card at the appointment)*

Name of Policy Holder ____Relationship __________________________

Policy Holder Date of Birth _____________________________________Social Security Number ________________

Name of Primary Insurance_____________________________________Policy Start Date: ______________________.

Policy/ID Number_________________________________Group/Plan Number ________________________________

I declare that the information listed above is accurate and complete.

____ ___________________

Print Patient Name/Parent or Guardian (for children under 18) Date

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Signature of Patient/Parent or Guardian (for children under 18)