FIRST CHOICE
Community Health Centers

- ☐ Anderson Creek Family Dentistry
- ☐ Anderson Creek Medical Center
- ☐ Angier Medical Center
- ☐ Benhaven Medical Center
- ☐ Lillington Health Center
- ☐ Mobile Unit (Dental/Medical)

Patient Data Form (Please Print)

Patient #: _____ Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____
Social Security Number: _____ - _____ - _____ Birth Date: _____ / _____ / _____

Gender Identity:
☐ Male ☐ Transgender Male/Female-to-Male ☐ Other
☐ Female ☐ Transgender Female/Male-to-Female ☐ Chose Not to Disclose

Sexual Orientation:
☐ Lesbian or Gay ☐ Straight (Not Lesbian or Gay) ☐ Bisexual
☐ Something Else ☐ Don't Know ☐ Chose Not to Disclose

Patient Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

Parent/Guardian Information

Parent/Guardian Name: _____
Parent/Guardian Social Security Number: _____ - _____ - _____ Birth Date: _____ / _____ / _____
Relationship to patient: _____ Phone: _____
Address (if different from patient): _____
Employer: _____ Employer Phone Number: _____

Insurance Information

Primary Insurance

Insurance Name: _____
Insurance ID#: _____ Group #: _____ Effective Date: _____
Policy Holders Name: Relationship to Patient: _____
Policy Holders Social Security Number: _____ - _____ - _____ Policy Holders Birth Date: _____
Policy Holders Employer: _____

Secondary Insurance

Insurance Name: _____
Insurance ID#: _____ Group #: _____ Effective Date: _____
Policy Holders Name: Relationship to Patient: _____
Policy Holders Social Security Number: _____ - _____ - _____ Policy Holders Birth Date: _____
Policy Holders Employer: _____

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Demographic Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Life Partner ☐ Legally Separated ☐ Unknown

Student: ☐ Full-time ☐ Part-time ☐ Not a Student

Employed: ☐ Full/Part-time ☐ Unemployed ☐ Self-employed ☐ Retired/Active Military

Housing Status: ☐ Doubling Up ☐ Homeless Shelter ☐ Not Homeless ☐ Public Housing
☐ Street ☐ Transitional ☐ Unknown

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American
☐ American Indian/Alaska Native ☐ White/Caucasian ☐ More than one race ☐ Refused to Report

Ethnicity: ☐ Hispanic or Latino **Veteran:** ☐ Yes ☐ No

Agricultural Status: ☐ Dependent of Migrant ☐ Dependent of Seasonal Worker
☐ Non-Agricultural Worker ☐ Seasonal Worker

Translation Services ☐ No ☐ Yes **Language:** _____

Household Income: $ _____ per: ☐ Hour ☐ Week ☐ Bi-weekly ☐ Year

Number of people in your household _____ **County of Residence** _____

Certification: I certify that the information given in this registration form is correct to the best of my knowledge.

Signature: _____ **Date:** _____
Relationship to patient: _____

Signature below acknowledges that you have been given the HIPAA Notice of our Privacy Practices.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until specifically revoked in writing:

_____

_____

Signature: _____ **Date:** _____