

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name:		First:		MI:	Nickname:
Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		State:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____					
<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
<input type="checkbox"/> I am employed		Employer: _____		<input type="checkbox"/> I am NOT employed	
				<input type="checkbox"/> I am retired	
				<input type="checkbox"/> Other: _____	
INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card. If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Home Number:		Cell Number:		Day/Work Number:	
<b>Is there someone you would like to give permission to speak on your behalf regarding your care? This allows them to obtain appointment, treatment and/or other information pertinent to your health care.</b> <input type="checkbox"/> NO <input type="checkbox"/> YES					
<b>NAME:</b>		<b>RELATIONSHIP:</b>		<b>PHONE:</b>	

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**Please check off all boxes that apply to you (or the patient that is being seen).**

<b>Race</b> Do you identify yourself as:	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> American Indian/ Alaskan Native
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> White
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan	<input type="checkbox"/> More than One Race
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Choose Not to Disclose Race
<b>Ethnicity</b> Do you identify yourself as:	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Mexican, Mexican American, or Chicano/a	<input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin	
	<input type="checkbox"/> Cuban		<input type="checkbox"/> Not Hispanic, Latino/a, or Spanish Origin	
			<input type="checkbox"/> Choose Not to Disclose Ethnicity	
<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
<b>Housing</b>	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing (Nursing Home, Group Home, or Assisting Living)	
	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

## INCOME INFORMATION

**PAYMENT OF BENEFITS AND INFORMATION RELEASE:**

I request that payment of authorized insurance benefits be made on my behalf to the Health Center for any services furnished to me by the Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the Health Center.

Using the table below, please indicate which column represents your TOTAL family/household income level based on the number of persons included in your household. This table is based on 2026 FPL guidelines:  
**(Circle one)**

**W            X            Y            Z            Prefer Not to Disclose**

	<b>W</b>	<b>X</b>	<b>Y</b>	<b>Z</b>
Family Size	Less than or Equal to	Between	Between	Equal to or Greater Than
<b>1</b>	\$15,960	\$15,961 – \$23,940	\$23,941 – \$31,920	\$31,921
<b>2</b>	\$21,640	\$21,641 – \$32,460	\$32,461 – \$43,280	\$43,281
<b>3</b>	\$27,320	\$27,321 – \$40,980	\$40,981 – \$54,640	\$54,641
<b>4</b>	\$33,000	\$33,001 – \$49,500	\$49,501 – \$66,000	\$66,001
<b>5</b>	\$38,680	\$38,681 – \$58,020	\$58,021 – \$77,360	\$77,361
<b>6</b>	\$44,360	\$44,361 – \$66,540	\$66,541 – \$88,720	\$88,721
<b>7</b>	\$50,040	\$50,041 – \$75,060	\$75,061 – \$100,080	\$100,081
<b>8</b>	\$55,720	\$55,721 – \$83,580	\$83,581 – \$111,440	\$111,441

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## NOTICES AND CONSENTS

### CONSENT FOR TREATMENT AT THE HEALTH CENTER:

1. I authorize the Health Center and its employees to use the information contained in my record for proper medical purposes, and for clinical improvement audits with information that would be de-identified.
2. I authorize the medical staff of the Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
3. I understand that the services offered at Sacopee Valley Health Center include medical care, podiatry, behavioral health, social services and dental care.
4. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

### CONFIDENTIALITY AND SECURITY:

SVHC is committed to protecting the confidentiality of patient health information and the health, safety and wellness of patients and staff.

The HIPAA Privacy Rule (45 CFR Part 160) establishes national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as "protected health information" or "PHI") and sets limits and conditions on the uses and disclosures of such information without an individual's authorization. The Rule also gives individuals rights over their protected health information, including rights to examine and obtain a copy of their health records.

SVHC may use secure surveillance cameras in the lobbies and other public areas of the building, as posted for public notification, for the safety and protection of all. SVHC will not videotape or otherwise record patient encounters except with the advance written consent of the patient and only for such dates, times and purposes as the patient may expressly agree. SVHC prohibits the taping by patients of health care encounters with SVHC staff, unless the staff person is notified in advance and consents in writing and the date, time and purpose of the recording can be documented in the patient record. By signing this form, the patient acknowledges that SVHC may withhold healthcare services if a patient requires, or otherwise attempts to videotape or record the delivery of healthcare services by SVHC.

SVHC providers and staff may use artificial intelligence (AI) tools, including AI-supported medical scribes, to assist with clinical decision-making and documentation related to my care, such as analyzing information, identifying patterns, generating clinical recommendations, and accurately documenting my visit. Final decisions about my care are always made by licensed healthcare providers using their professional judgment and expertise.

In some visits, a live remote medical scribe may assist with real-time documentation. The remote scribe does not provide care or make clinical decisions and works under the direct supervision of my provider.

### NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been provided with an opportunity to take a copy of the health center's Notice of Privacy Practices and to ask any questions I have about it.

### SIGNATURE:

By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

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Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		City:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____					
<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
<input type="checkbox"/> I am employed		Employer: _____		<input type="checkbox"/> I am NOT employed	
				<input type="checkbox"/> I am retired	
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INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card.            If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Home Number:		Cell Number:		Day/Work Number:	
<b>Is there someone you would like to give permission to speak on your behalf regarding your care?            This allows them to obtain appointment, treatment and/or other information pertinent to your health care.</b> <input type="checkbox"/> NO <input type="checkbox"/> YES					
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<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
<b>Housing</b>	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing (Nursing Home, Group Home, or Assisting Living)	
	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

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### SIGNATURE:

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\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name:		First:		MI:	Nickname:
Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		State:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____					
<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
<input type="checkbox"/> I am employed		Employer: _____		<input type="checkbox"/> I am NOT employed	
				<input type="checkbox"/> I am retired	
				<input type="checkbox"/> Other: _____	
INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card.                  If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Home Number:		Cell Number:		Day/Work Number:	
<b>Is there someone you would like to give permission to speak on your behalf regarding your care?                  This allows them to obtain appointment, treatment and/or other information pertinent to your health care.</b> <input type="checkbox"/> NO <input type="checkbox"/> YES					
<b>NAME:</b>		<b>RELATIONSHIP:</b>		<b>PHONE:</b>	

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

## OTHER REQUIRED INFORMATION

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**Please check off all boxes that apply to you (or the patient that is being seen).**

<b>Race</b> Do you identify yourself as:	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> American Indian/ Alaskan Native
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> White
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan	<input type="checkbox"/> More than One Race
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Choose Not to Disclose Race
<b>Ethnicity</b> Do you identify yourself as:	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Mexican, Mexican American, or Chicano/a	<input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin	
	<input type="checkbox"/> Cuban		<input type="checkbox"/> Not Hispanic, Latino/a, or Spanish Origin	
			<input type="checkbox"/> Choose Not to Disclose Ethnicity	
<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
<b>Housing</b>	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing (Nursing Home, Group Home, or Assisting Living)	
	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

## INCOME INFORMATION

**PAYMENT OF BENEFITS AND INFORMATION RELEASE:**

I request that payment of authorized insurance benefits be made on my behalf to the Health Center for any services furnished to me by the Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the Health Center.

Using the table below, please indicate which column represents your TOTAL family/household income level based on the number of persons included in your household. This table is based on 2026 FPL guidelines:  
**(Circle one)**

**W            X            Y            Z            Prefer Not to Disclose**

Family Size	<b>W</b>	<b>X</b>	<b>Y</b>	<b>Z</b>
	Less than or Equal to	Between	Between	Equal to or Greater Than
<b>1</b>	\$15,960	\$15,961 – \$23,940	\$23,941 – \$31,920	\$31,921
<b>2</b>	\$21,640	\$21,641 – \$32,460	\$32,461 – \$43,280	\$43,281
<b>3</b>	\$27,320	\$27,321 – \$40,980	\$40,981 – \$54,640	\$54,641
<b>4</b>	\$33,000	\$33,001 – \$49,500	\$49,501 – \$66,000	\$66,001
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<b>7</b>	\$50,040	\$50,041 – \$75,060	\$75,061 – \$100,080	\$100,081
<b>8</b>	\$55,720	\$55,721 – \$83,580	\$83,581 – \$111,440	\$111,441

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

## NOTICES AND CONSENTS

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2. I authorize the medical staff of the Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
3. I understand that the services offered at Sacopee Valley Health Center include medical care, podiatry, behavioral health, social services and dental care.
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*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name:		First:		MI:	Nickname:
Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		State:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____					
<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
<input type="checkbox"/> I am employed		Employer: _____		<input type="checkbox"/> I am NOT employed	
				<input type="checkbox"/> I am retired	
				<input type="checkbox"/> Other: _____	
INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card.</b> <b>If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Home Number:		Cell Number:		Day/Work Number:	
<b>Is there someone you would like to give permission to speak on your behalf regarding your care?</b> <b>This allows them to obtain appointment, treatment and/or other information pertinent to your health care.</b> <input type="checkbox"/> NO <input type="checkbox"/> YES					
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<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
<b>Housing</b>	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing (Nursing Home, Group Home, or Assisting Living)	
	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

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*Date*

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Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		City:		State:	
Zip Code			Zip Code		
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Email: _____					
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				<input type="checkbox"/> Other: _____	
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<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
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	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

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<b>3</b>	\$27,320	\$27,321 – \$40,980	\$40,981 – \$54,640	\$54,641
<b>4</b>	\$33,000	\$33,001 – \$49,500	\$49,501 – \$66,000	\$66,001
<b>5</b>	\$38,680	\$38,681 – \$58,020	\$58,021 – \$77,360	\$77,361
<b>6</b>	\$44,360	\$44,361 – \$66,540	\$66,541 – \$88,720	\$88,721
<b>7</b>	\$50,040	\$50,041 – \$75,060	\$75,061 – \$100,080	\$100,081
<b>8</b>	\$55,720	\$55,721 – \$83,580	\$83,581 – \$111,440	\$111,441

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

## NOTICES AND CONSENTS

### CONSENT FOR TREATMENT AT THE HEALTH CENTER:

1. I authorize the Health Center and its employees to use the information contained in my record for proper medical purposes, and for clinical improvement audits with information that would be de-identified.
2. I authorize the medical staff of the Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
3. I understand that the services offered at Sacopee Valley Health Center include medical care, podiatry, behavioral health, social services and dental care.
4. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

### CONFIDENTIALITY AND SECURITY:

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SVHC may use secure surveillance cameras in the lobbies and other public areas of the building, as posted for public notification, for the safety and protection of all. SVHC will not videotape or otherwise record patient encounters except with the advance written consent of the patient and only for such dates, times and purposes as the patient may expressly agree. SVHC prohibits the taping by patients of health care encounters with SVHC staff, unless the staff person is notified in advance and consents in writing and the date, time and purpose of the recording can be documented in the patient record. By signing this form, the patient acknowledges that SVHC may withhold healthcare services if a patient requires, or otherwise attempts to videotape or record the delivery of healthcare services by SVHC.

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In some visits, a live remote medical scribe may assist with real-time documentation. The remote scribe does not provide care or make clinical decisions and works under the direct supervision of my provider.

### NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been provided with an opportunity to take a copy of the health center's Notice of Privacy Practices and to ask any questions I have about it.

### SIGNATURE:

By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name:		First:		MI:	Nickname:
Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		City:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____					
<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
<input type="checkbox"/> I am employed		Employer: _____		<input type="checkbox"/> I am NOT employed	
				<input type="checkbox"/> I am retired	
				<input type="checkbox"/> Other: _____	
INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card.                  If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Home Number:		Cell Number:		Day/Work Number:	
<b>Is there someone you would like to give permission to speak on your behalf regarding your care?                  This allows them to obtain appointment, treatment and/or other information pertinent to your health care.</b> <input type="checkbox"/> NO <input type="checkbox"/> YES					
<b>NAME:</b>		<b>RELATIONSHIP:</b>		<b>PHONE:</b>	

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

## OTHER REQUIRED INFORMATION

**This site is a Federally Qualified Health Center (FQHC) which means we receive a federal grant that allows us to provide a discounted fee program to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients.** The *only* reason this information is collected is for reporting purposes and we respect that this is personal and confidential information. Your help is very much appreciated.

**Please check off all boxes that apply to you (or the patient that is being seen).**

<b>Race</b> Do you identify yourself as:	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> American Indian/ Alaskan Native
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> White
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan	<input type="checkbox"/> More than One Race
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Choose Not to Disclose Race
<b>Ethnicity</b> Do you identify yourself as:	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Mexican, Mexican American, or Chicano/a	<input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin	
	<input type="checkbox"/> Cuban		<input type="checkbox"/> Not Hispanic, Latino/a, or Spanish Origin	
			<input type="checkbox"/> Choose Not to Disclose Ethnicity	
<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
<b>Housing</b>	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing (Nursing Home, Group Home, or Assisting Living)	
	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

## INCOME INFORMATION

**PAYMENT OF BENEFITS AND INFORMATION RELEASE:**

I request that payment of authorized insurance benefits be made on my behalf to the Health Center for any services furnished to me by the Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the Health Center.

Using the table below, please indicate which column represents your TOTAL family/household income level based on the number of persons included in your household. This table is based on 2026 FPL guidelines:  
**(Circle one)**

**W            X            Y            Z            Prefer Not to Disclose**

	<b>W</b>	<b>X</b>	<b>Y</b>	<b>Z</b>
Family Size	Less than or Equal to	Between	Between	Equal to or Greater Than
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# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

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### SIGNATURE:

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\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name:		First:		MI:	Nickname:
Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		State:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____					
<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
<input type="checkbox"/> I am employed		Employer: _____		<input type="checkbox"/> I am NOT employed	
				<input type="checkbox"/> I am retired	
				<input type="checkbox"/> Other: _____	
INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card.            If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Home Number:		Cell Number:		Day/Work Number:	
<b>Is there someone you would like to give permission to speak on your behalf regarding your care?            This allows them to obtain appointment, treatment and/or other information pertinent to your health care.</b> <input type="checkbox"/> NO <input type="checkbox"/> YES					
<b>NAME:</b>		<b>RELATIONSHIP:</b>		<b>PHONE:</b>	

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<b>Ethnicity</b> Do you identify yourself as:	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Mexican, Mexican American, or Chicano/a	<input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin	
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<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
<b>Housing</b>	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing (Nursing Home, Group Home, or Assisting Living)	
	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

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*Patient/Guardian Signature*

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*Date*

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name:		First:		MI:	Nickname:
Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		State:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
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<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
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INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card.</b> <b>If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
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	<input type="checkbox"/> Cuban		<input type="checkbox"/> Not Hispanic, Latino/a, or Spanish Origin	
			<input type="checkbox"/> Choose Not to Disclose Ethnicity	
<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
<b>Housing</b>	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing (Nursing Home, Group Home, or Assisting Living)	
	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
<b>Military Status:</b>	Are you a Veteran of the U.S. Military <input type="checkbox"/> YES <input type="checkbox"/> NO			

## INCOME INFORMATION

**PAYMENT OF BENEFITS AND INFORMATION RELEASE:**

I request that payment of authorized insurance benefits be made on my behalf to the Health Center for any services furnished to me by the Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the Health Center.

Using the table below, please indicate which column represents your TOTAL family/household income level based on the number of persons included in your household. This table is based on 2026 FPL guidelines:  
**(Circle one)**

**W            X            Y            Z            Prefer Not to Disclose**

	<b>W</b>	<b>X</b>	<b>Y</b>	<b>Z</b>
Family Size	Less than or Equal to	Between	Between	Equal to or Greater Than
<b>1</b>	\$15,960	\$15,961 – \$23,940	\$23,941 – \$31,920	\$31,921
<b>2</b>	\$21,640	\$21,641 – \$32,460	\$32,461 – \$43,280	\$43,281
<b>3</b>	\$27,320	\$27,321 – \$40,980	\$40,981 – \$54,640	\$54,641
<b>4</b>	\$33,000	\$33,001 – \$49,500	\$49,501 – \$66,000	\$66,001
<b>5</b>	\$38,680	\$38,681 – \$58,020	\$58,021 – \$77,360	\$77,361
<b>6</b>	\$44,360	\$44,361 – \$66,540	\$66,541 – \$88,720	\$88,721
<b>7</b>	\$50,040	\$50,041 – \$75,060	\$75,061 – \$100,080	\$100,081
<b>8</b>	\$55,720	\$55,721 – \$83,580	\$83,581 – \$111,440	\$111,441

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

## NOTICES AND CONSENTS

### CONSENT FOR TREATMENT AT THE HEALTH CENTER:

1. I authorize the Health Center and its employees to use the information contained in my record for proper medical purposes, and for clinical improvement audits with information that would be de-identified.
2. I authorize the medical staff of the Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
3. I understand that the services offered at Sacopee Valley Health Center include medical care, podiatry, behavioral health, social services and dental care.
4. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

### CONFIDENTIALITY AND SECURITY:

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In some visits, a live remote medical scribe may assist with real-time documentation. The remote scribe does not provide care or make clinical decisions and works under the direct supervision of my provider.

### NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been provided with an opportunity to take a copy of the health center's Notice of Privacy Practices and to ask any questions I have about it.

### SIGNATURE:

By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name:		First:		MI:	Nickname:
Social Security Number:			Date of Birth:     /     /		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			Physical/Local Address: <input type="checkbox"/> Same as mailing address		
Street:			Street:		
City:		State:		City:	
State:		State:		State:	
Zip Code			Zip Code		
<b>Primary Care Provider:</b> <input type="checkbox"/> Andrea Stemm, PA <input type="checkbox"/> Christopher Todd Kitchens, DO <input type="checkbox"/> Fredericka Sadovnikoff, PA <input type="checkbox"/> Gene Royer, DO <input type="checkbox"/> Gregory Griffin, PA <input type="checkbox"/> Olivia Hatch, FNP <input type="checkbox"/> NON-SVHC _____					
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____					
<b>Please enter telephone number and place a ✓ mark in the box next to the phone # you prefer us to call first.</b>					
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Day/Work Phone:		<input type="checkbox"/> Cell Phone:	
Email: _____					
EMPLOYMENT INFORMATION					
<input type="checkbox"/> I am employed		Employer: _____		<input type="checkbox"/> I am NOT employed	
				<input type="checkbox"/> I am retired	
				<input type="checkbox"/> Other: _____	
INSURANCE INFORMATION					
<b>Please have the receptionist scan your insurance card.            If your insurance card is not current or available, you will be billed.</b>					
<input type="checkbox"/> I have insurance, listed below			<input type="checkbox"/> I do NOT have insurance at this time		
Primary Insurance:			Secondary Insurance:		
Subscriber's Name:			Subscriber's Name:		
ID Number:			ID Number:		
Dental Insurance:		Subscriber's Name:		ID Number:	
PERSON RESPONSIBLE FOR PAYMENT			<input type="checkbox"/> SELF - If not self, please fill in the spaces below		
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Mailing Address: (If different than patient)			City:		State:     Zip:
Home Number:		Cell Number:		Day/Work Number:	
EMERGENCY CONTACT INFORMATION			<input type="checkbox"/> NONE - I have no emergency contact		
Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Home Number:		Cell Number:		Day/Work Number:	
<b>Is there someone you would like to give permission to speak on your behalf regarding your care?            This allows them to obtain appointment, treatment and/or other information pertinent to your health care.</b> <input type="checkbox"/> NO <input type="checkbox"/> YES					
<b>NAME:</b>		<b>RELATIONSHIP:</b>		<b>PHONE:</b>	

# SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

## OTHER REQUIRED INFORMATION

**This site is a Federally Qualified Health Center (FQHC) which means we receive a federal grant that allows us to provide a discounted fee program to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients.** The *only* reason this information is collected is for reporting purposes and we respect that this is personal and confidential information. Your help is very much appreciated.

**Please check off all boxes that apply to you (or the patient that is being seen).**

<b>Race</b> Do you identify yourself as:	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> American Indian/ Alaskan Native
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> White
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan	<input type="checkbox"/> More than One Race
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Choose Not to Disclose Race
<b>Ethnicity</b> Do you identify yourself as:	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Mexican, Mexican American, or Chicano/a	<input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin	
	<input type="checkbox"/> Cuban		<input type="checkbox"/> Not Hispanic, Latino/a, or Spanish Origin	
			<input type="checkbox"/> Choose Not to Disclose Ethnicity	
<b>Agricultural Worker Status</b>	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Not Applicable	
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	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Street	<input type="checkbox"/> Other		
<b>Do you need</b>	<input type="checkbox"/> An Interpreter	<input type="checkbox"/> ASL Interpreter	<input type="checkbox"/> Not Applicable	
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\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*