Head Start Patient Registration Form

As an (FQHC) Federal Qualified Health Center, Healing Community Center is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Not Reported/Refused if you do not wish to answer a specific question. Thank you for choosing Healing Community Center as your health care provider.

PATIENT IDENTIFICATION Today's Date: _____

Patient First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Social Security#: _____ Legal Sex: ☐Male ☐Female

Head Start School _____

CONTACT INFORMATION

Address: _____ Apt./Suite#: _____ City: _____

State: _____ Zip Code: _____ Email: _____ ☐ No Email

Home#: _____ Cell#: _____

Emergency Contact: _____ **Relationship to patient:** _____

Home#: _____ Cell#: _____ Work#: _____

DEMOGRAPHICS

Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Patient declined ☐ Other _____

Race: ☐ Black/African American ☐ White/Caucasian American ☐ Asian ☐ Native American ☐ Alaskan ☐ Hawaiian

☐ Pacific Islander ☐ Patient declined ☐ Other _____ **Ethnicity:** ☐ Hispanic ☐ Latin ☐ Not Hispanic or Latin

Sexual Orientation: ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose

☐ Other, please describe _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender (F to M) ☐ Transgender (M to F) ☐ Neither exclusively M nor F

☐ Choose not to disclose ☐ Other _____ **Assigned Sex at birth:** ☐ Male ☐ Female ☐ Choose not to disclose

Family size: _____ | **Income: $**_____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually ☐ Choose not to disclose

INSURANCE INFORMATION

Medicaid Provider/ID: _____ Other Insurance (name/ID): _____

AUTHORIZATION FOR TREATMENT

I hereby voluntarily give my consent for _____ to receive health services with
(Name of Child)
HEALing Community Center. I further authorize any physician or physician-designated health professional working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health care. I understand that my signing this consent allows the physician and professional clinic staff of HEALing Community Center to provide comprehensive health services **which includes physical, developmental, and dental health services.** I authorize periodic dental examinations for my child, which may include fluoride treatment, and other prescribed methods for evaluation and management of my child's dental health.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans to **HEALing Community Center.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges if paid by said insurance. I hereby authorize the assignee to release all information necessary to secure the payment:

_____	_____	_____
(PRINT) Parent or Legal Guardian	**(SIGN) Parent or Legal Guardian**	**Date**