Mountain Community Health

61 Pine Street
Bristol, VT
Phone (802) 453-3911 Primary Care Fax (802) 453-6105 Dental Care Fax (802)453-3983

Patient Registration Form

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

Physical Address (if different than above): _____

Home Phone: ( )_____ **Cell Phone**: ( )_____ **Work Phone**: : ( )_____

How would you like us to remind you of appointments: ☐ Phone (preferred #) _____ ☐ Text

Social Security # _____-_____-_____ **E-mail**:_____

Would you like access to our online Patient Portal: ☐ Yes ☐No **Primary Care Provider:** _____

Emergency Contact: _____**Phone**: _____**Relationship:** _____

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight ☐ Bi-sexual ☐ Other ☐ Chose not to disclose Sexual Orientation

Gender: ☐ Male ☐ Female ☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female

☐ Choose not to disclose Gender

Sex at Birth: ☐ Male ☐ Female

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

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐Military ☐ Unemployed

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

Employer Name and Address: _____

Pharmacy Name and Location: _____ **Mail Order Pharmacy:** _____

Responsible Party Information (Who is Responsible for Paying the Bill) – Complete Only if Not Same as Patient:

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian (Proof of legal status required for treatment)

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

Physical Address (if different than above): _____

Home Phone: ( )_____ **Cell Phone:** ( )_____**Work Phone:** ( )_____

☐ **I do not have Medical Insurance** ☐ **I would like to apply for the Sliding Fee Scale Discount**

Primary Medical Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Secondary Medical Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Primary Dental Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Secondary Dental Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

MCH is a Federally Qualified Health Center, and we are required to collect the following information:

Are you a Seasonal Worker? ☐ Yes ☐ No

Are you a Migrant Worker? ☐ Yes ☐ No

Are you a United States Veteran? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

If yes, ☐ Homeless ☐ Shelter ☐ Transitional ☐ Double up ☐ Street ☐ Other _____

How many people currently live in your household (including yourself): _____

Annual Household Income:_____ ☐ Choose to not disclose Income

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other _____ **Interpreter Needed?** ☐ Yes ☐ No

Race:
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Guamanian/Chamorro ☐ Samoan ☐ Black/African American
☐ American Indian/Alaska Native ☐ White ☐ More than one Race ☐ Choose not to disclose Race

Ethnicity: ☐ Mexican/Mexican American/Chicano ☐ Puerto Rican ☐ Another Hispanic Latino/a or Spanish
☐ Not-Hispanic/Latino/a or Spanish ☐ Choose not to Disclose Ethnicity

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☐ I have read the Notice of Privacy Practices for Mountain Community Health

☐ I have declined to read the Notice of Privacy Practices for Mountain Community Health. I am aware that there is a copy posted in the office.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Print Patient/Guardian Name Relationship to Patient