SOUTH BOSTON COMMUNITY HEALTH CENTER

REGISTRATION FORM

(Please Print)

Today's date:	General PCP:	Insurance PCP:

PATIENT INFORMATION

Patient's last name: **First:** **Middle Initial**	**Marital status** (circle one): Single / Married / Divorced / Legally Separated /Widowed
Mailing Address (Street, City, State, Zip Code):	**Birth date:** / / **Sex:** ❑M ❑F ❑ Trans: Male to Female ❑ Trans: Female to Male ❑ Unknown
Residential Address, if different from Mailing (Street, City, State, Zip Code):	**Primary Phone no.:** ( )
E-mail Address:	

Social Security Number:	**Primary Language Spoken:**	**Interpreter Needed:** ❑ Yes ❑ No	**Ethnicity:** ❑ Hispanic ❑ Non-Hispanic

Race (circle one):

Alaskan Native/ American Indian/ Asian/ Black or African American/ Native Hawaiian/ Pacific Islander/ White Caucasian/ Unknown

Citizenship Status: ❑US Citizen ❑Perm. Resident ❑Non US Citizen ❑Other	**Veteran Status:** ❑Veteran ❑ Non-Veteran	**Public Housing?** ❑ Yes ❑ No

Homeless Status: ❑ Not Homeless ❑ Transitional Housing ❑ Street ❑ Living with Others ❑ Homeless Unknown Shelter ❑ Living in Shelter (specify): _____

Family Size (cannot be zero):	**Annual Household Income:** $

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Guarantor *Required for patients 18 and younger* (This is the person who is responsible for the bill):	**Relationship to patient:**	**Guarantor's Birth date:** / /	**Guarantor's Primary Phone:** ( )

Guarantor's Address (if different from patient's):	**Guarantor's SSN**:

Is the guarantor a patient here? ❑ Yes ❑ No	Is the patient covered by insurance? ❑ Yes ❑ No

Name of Primary insurance plan:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other (specify): _____

Subscriber's name (For MassHealth, subscriber = patient):	**Subscriber's SSN:**	**Subscriber's Birth date:** / /

Name of secondary insurance (if applicable):	**Subscriber's name:**

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other (specify): _____

IN CASE OF EMERGENCY

Contact Last Name: **First:**	**Relationship to patient:**	**Primary phone:** ( )	**Secondary phone:** ( )

The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*