



COMMUNITY HEALTH CENTERS OF BENTON AND LINN COUNTIES

Full Registration Form

CLIENT INFORMATION

Name: _____ SSN: _____
Last First Middle

Other Name(s) Used: _____

Birthdate: _____ Last Name at Birth: _____ Female Male
Month / Day / Year

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip: _____

Please provide us with at least two contact phone numbers for you and tell us what kind of phone numbers they are:

() _____ Home Work Cell phone Pager Message

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Do we need to contact you at a different mailing address, phone number or through an alternate method for confidential issues? Yes No

Do you need an interpreter? Yes No What is your primary language? _____

Which of the following best describes your:

Race- Mark Alaskan Native American Native Asian Black **Ethnicity** Hispanic
All that apply Native Hawaiian Pacific Islander White Non - Hispanic

LOCAL EMERGENCY CONTACT

Name: _____

Home Phone: _____ Alternate Phone: _____

Relationship to Client: _____ Client's Legal Guardian? Yes No

GUARANTOR (Person responsible for Payment-list insurance information in next section)

Name: _____ Last Name at Birth: _____
Last First Middle

Billing Address: _____ Birthdate: _____ Phone Number: _____
Month / Day / Year

City: _____ State: _____ Zip: _____ Relationship to Client: _____

INSURANCE INFORMATION

Do you have health insurance? Yes No I am uninsured or have insurance with a very high deductible and would like to apply for the sliding fee scale to help cover the cost of my visits. (You will be asked to provide verification of your income by providing check stubs or income tax documents.)

Name of Primary Insurance: _____

Insurance Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name of Policy Holder: _____ Relationship to Client: _____
Last First Middle

Mailing Address: _____ Phone: _____

Policy Holder's SSN: _____ Policy Holder's Birth Date: _____ Female Male
Month / Day / Year

Insurance ID: _____

Group #: _____

Do you have additional insurance? Yes No

Name _____
Client # _____ DOB _____