Welcome and thank you for selecting Joseph Addabbo Family Health Center, Inc.

PATIENT REGISTRATION FORM

*****PLEASE PRINT NEATLY*****

PATIENT INFORMATION

Patients Last Name:	First Name:	Middle Initial:	▫ Mr. ▫ Miss ▫ Mrs. ▫ Ms.	Date of Birth: MM/DD/YY	Age	Gender at birth M / F ______ Transgender [ ]

Patients Address:	City/Town:	Apt#	State	Zip Code	Social Security #

Do you live in Public Housing? ▫ YES ▫ NO	Are you a Veteran? ▫ YES ▫ NO	Are you disabled? ▫ YES ▫ NO	Are you Homeless? ▫ YES ▫ NO	Sex Orientation: Birth - 17 yrs. (not mandated to report) ▫ Gay/Lesbian ▫ Straight/ Heterosexual ▫ Bisexual ▫ Something else ▫ Don't know ▫ Choose not to disclose

Home Telephone #	Cell phone #	Preferred Language:	Email Address:	# Of Dependents

Ethnicity: ▫ Hispanic or Latino ▫ Not Hispanic or Latino ▫ Decline to answer	Race: ▫ White ▫ Black or African American ▫ Decline to answer ▫ Asian ▫ American Indian or Alaska Native ▫ Other ▫ Native Hawaiian or Other Pacific Islander	Marital status: ▫M ▫ S ▫ W ▫D ▫ Sep

Pharmacy Name:	Pharmacy Phone #	▫ Check here if uninsured/underinsured

Primary Insurance Name ID #	Secondary Insurance Name ID #	Policyholder's Name: Policyholder's Date of Birth: / /

PARENT/ LEGAL GUARDIAN / CAREGIVER INFORMATION

Parent/Guardians Last Name:	First Name:	Middle Initial	Gender	Date of Birth

▫ Check here if patient resides with Parent/Guardian ▫ If NO please provide the address below	Relationship to Patient: ▫Parent ▫Guardian ▫ Other	Email Address:

Address:	Primary Tel #	Work #	Cell#

EMERGENCY CONTACT

Name:	Relationship to Patient:	Phone #	Additional Phone #

PATIENT CERTIFICATION

I CERTIFY THAT ALL INFORMATION GIVEN BY ME IS TRUE. I UNDERSTAND THAT THE JOSEPH P. ADDABBO FAMILY HEALTH CENTER, INC. WILL PROVIDE HEALTH CARE UNDER THE MANAGEMENT OF THE MEDICAL, DENTAL AND OTHER ALLIED PROFESSIONALS AND NURSING STAFF ASSISTED BY OTHER EMPLOYEES TO PROVIDE CARE AND TO ADMINISTER SUCH DIAGNOSTIC AND THERAPEUTIC TEST, PROCEDURE AND TREATMENT AS THE JUDGEMENT OF THE LICENSED PROFESSIONAL STAFF, MAY BE DEEMED NECESSARY OR ADVISABLE. THE JOSEPH P. ADDABBO FAMILY HEALTH CENTER, INC. IS NOT LIABLE FOR ANY ACTS OR OMISSIONS IN FOLLOWING DOCTOR'S ORDERS. I CONSENT TO ANY SERVICES RENDERED TO ME OR MY DEPENDENTS. **I ACCEPT RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT ALL FEES ARE DUE WHEN SERVICES ARE RENDERED.** I AUTHORIZED PAYMENT OF HEALTH CARE BENEFITS TO THE JOSEPH P. ADDABBO FAMILY HEALTH CENTER. I ACCEPT RESPONSIBILITY FOR ANY FEES INCURRED IN THE COLLECTION OF THIS ACCOUNT. I AUTHORIZE THE JOSEPH P. ADDABBO FAMILY HEALTH CENTER, INC. TO RELEASE ANY INFORMATION NECESSARY TO PROCESS THIS OR ANY RELATED CLAIMS. I HAVE RECEIVED A COPY OF THE PATIENTS' BILL OF RIGHTS. A COPY OF THIS RELEASE IS USABLE IN PLACE OF ORIGINAL. **IN THE INTEREST OF YOUR MEDICAL CARE, YOU ARE RESPONSIBLE TO MAKE SURE YOUR PROVIDER HAS YOUR UP TO DATE TELEPHONE NUMBER(S) AND ADDRESS. YOUR PROVIDER MAY HAVE TO REACH YOU REGARDING YOUR HEALTH CARE. BY SIGNING THIS FORM, I GIVE THE JOSEPH P. ADDABBO FAMILY HEALTH CENTER CONSENT TO CHECK MY EXTERNAL MEDICATION HISTORY.**

SIGNATURE:	PRINT NAME	DATE

RELATIONSHIP TO PATIENT ▫ SELF ▫ PARENT ▫ LEGAL GUARDIAN ▫ OTHER ________________

WITNESS/CLERK

SIGNATURE:	PRINT NAME	DATE