Streamlined Registration form for Tri-Cities Community Health

Patient/Employee Name (Last, First):		Date of Birth (mm/dd/yyyy):	
Address:	City:	State:	Zip Code:
Phone Number:		Gender Identity: (Male, Female, Trans M/F, Non Binary Other)	
Race: American Indian or Alaska Native, Asian, Black, Other Pacific Islander, White or Other **Ethnicity:** Hispanic or Latino Not Hispanic or Latino		Language: **Spanish** **English** **Other** **Homeless status:** Doubling Up Homeless Supportive Housing Street Transitional Other Unknown	
Marital status: **Public Housing**: (Yes / No) – Patient Declined		**Farmworker:** (Yes/ No) **Migrant** **or** **Seasonal**	

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read and understand the HIPAA/Privacy Policy for TRI-CITIES COMMUNITY HEALTH

Signed_____ **Date:** _____

I hereby assign my insurance benefits to be paid directly to the healthcare provider and authorize TRI-CITIES COMMUNITY HEALTH to release medical information required to process my claim. I have read and understand the Financial Policy for TRI-CITIES COMMUNITY HEALTH.

Signed_____ **Date:** _____

Medical Insurance:

Name_____

Identification number_____

Secondary Medical Insurance _____