COMMUNITY HEALTH CENTER OF BUFFALO, INC.

Today's Date: _____

Registration Form

☐ New Patient Information [Referring Physician] _____ ☐ Updated Patient Information

How did you hear of us: News ☐ Radio ☐ Billboard ☐ Friend/Relative ☐ Website ☐ Other ☐_____

Patient Last Name _____First Name_____

Address _____City _____State _____Zip _____

Date of Birth ____/____/_____ Social Security # _____ Phone # _____

Cell Phone #:_____ Email Address: _____

Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Maiden Name _____

In Case of Emergency Contact _____ Phone _____

Person responsible for the bill; if other than patient: Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐

Last Name _____ First Name_____

Date of Birth ____/____/_____ Social Security # _____ Phone # _____

Address _____City _____State _____Zip _____

Insurance Guarantor Last Name _____First Name _____

Date of Birth ____/____/_____ Guarantor Social Security # _____ Phone # _____

Patient Relationship to Guarantor: Self ☐ Spouse ☐ Child ☐ Other ☐

Address _____City _____State _____Zip _____

Employer _____Employer Address _____

Primary Insurance Carrier Name: _____Billing ID # _____

Secondary Insurance Carrier Name: _____Billing ID # _____

This confidential data is not reported on an individual basis.

Household Income

My Annual household Income is: _____How many people are in your household: _____

Race/Ethnicity

_____ Asian _____ Black/African American [*not Hispanic*] _____ White [*not Hispanic*]
_____ Unreported/Unknown _____ Pacific Islander _____ American Indian/Alaska Native
_____ Hispanic [*all races*] _____ Need Interpretation Services [Bilingual]

COMMUNITY HEALTH CENTER OF BUFFALO, INC.

Today's Date: _____

Health Questionnaire

Patient Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/_____ Social Security # _____ Phone # _____

In Case of Emergency Contact _____ Phone _____

If you are completing this form for another person, what is your relationship to this person? _____

Please Answer Each Question

1. Are you under the care of a medical doctor? **YES** ☐ **NO** ☐
2. Are you currently taking any medicine or drugs? **YES** ☐ **NO** ☐
   If so, please list them: _____
3. Are you allergic to or made sick by: latex, penicillin, codeine, aspirin or any other drugs or medicines?
   YES ☐ **NO** ☐
   If yes please list them: _____
4. Have you ever had a bleeding problem requiring special treatment: **YES** ☐ **NO** ☐
5. (Women) Are you pregnant now? **YES** ☐ **NO** ☐ If yes, what month? _____
6. Do you wear a pacemaker? **YES** ☐ **NO** ☐
7. Check any of the following which you have now, or have had in the past.

Alcoholism		Epilepsy		Jaundice		Rheumatic Fever	
Anemia		Heart Murmur		Kidney Disease		Sinus Trouble	
Artificial Heart Valve		Heart Trouble		Mental Retardation or		Stroke	
Asthma		Hepatitis		Developmental Disorder		Thyroid Disease	
Diabetes		High Blood Pressure		Prolapsed Mitral Valve		Tuberculosis	
Emphysema		HIV / AIDS		Psychiatric Treatment		Other	

8. List any other health problems _____

Physician's Name _____ Phone _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or my medicines change, I will inform the dentist at the next appointment.

_____ Signature of patient or Parent/Guardian (if minor)

_____ Signature of Dental Provider