NEW PATIENT REGISTRATION FORM

CVHS ACCT: _____

PATIENT INFORMATION			
Last Name, Suffix:	First Name:	Middle Initial:	Preferred Name:
Mailing Address:			
Street Address (if different from mailing address):	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth: ____/____/_____	Sex Listed on Birth Certificate: ☐ Male ☐ Female	Social Security:	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated ☐ Partner	Sexual Orientation: ☐ Straight or heterosexual ☐ Bisexual ☐ Lesbian, gay, or homosexual ☐ Don't know ☐ Choose not to disclose ☐ Something else		

RESPONSIBLE PARTY (GUARANTOR) ☐ Self (if self, leave blank) ☐ Parent/Legal Guardian ☐ Spouse			
First Name:	Middle Initial:	Last Name, Suffix:	
Mailing Address:	City:	State:	Zip Code:
Guarantor's Date of Birth:	Guarantor's Social Security:	Guarantor's Sex:	Guarantor's Phone Number:
Is Guarantor a patient at CVHS? ☐ Yes ☐ No			
Emergency Contact:	HIPAA: (Circle one) Yes or No		
Relationship:	Telephone Number:		

EMPLOYER INFORMATION	
Employer Name:	Employer Address:

INSURANCE INFORMATION		
Name of primary medical insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Name of secondary insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Name of dental insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify _____		
Preferred Pharmacy:	Location:	

DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

The government HIPAA regulations require permission from the patient in order for any healthcare professional to speak with family, friends or caregivers regarding your protected health information, except in cases of emergency.

Please list your choice of individuals for us to disclose/discuss your private health information. Please list those you authorize (i.e.: spouse, children, sibling or caregiver) and remember that even your spouse needs to be listed if it is okay for us to speak with them.

Name:	DOB: ____/____/_____	Phone:	HIPAA: (Circle one) Yes or No

Mailing Address:	City	State:	Zip Code:

Tell us the best way to contact you for appointment reminders, messages, etc.:
☐ Home ☐ Cell ☐ Text Message ☐ Email
Home ☐ Brief (no clinical information) ☐ Extended (some clinical information)
Cell ☐ Brief (no clinical information) ☐ Extended (some clinical information)

Patient's email address:

DEMOGRAPHIC INFORMATION

In what **county** do you live in?:

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Other Pacific Islander ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian ☐ Alaska Native ☐ Other Race ☐ Unreported/Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to report

Language: ☐ English ☐ Spanish ☐ Other	Translator: ☐ Yes ☐ No	

Are you a veteran?: ☐ Yes ☐ No
Are you migrant?: ☐ Yes ☐ No
Are you limited in English Proficiency?: ☐ Yes ☐ No
Are you a seasonal worker?: ☐ Yes ☐ No
Are you homeless?: ☐ Yes ☐ No
Are you in Public Housing?: ☐ Yes ☐ No
Do you have an affiliation to a student or staff member at the school based clinic for dental? ☐ Yes ☐ No
Do you know about other CVHS dental sites nearby? ☐ Yes ☐ No

Please read the items below and initial beside each item, then sign and date as noted.	**Initial**
CONSENT TO TREATMENT: I authorize and consent to receive medical, dental, pharmacy, behavioral health, psychiatric services, case management, telehealth services, and care coordination for myself and/or my minor child(ren).	
AI CONSENT: I consent to receive services within CVHS and acknowledge that AI-assisted tools may be used to support clinical care and documentation. All privacy laws, such as HIPAA, will apply while utilizing AI. If I have any questions about the use of AI, I will consult my provider. Consent may be revoked at any time.	
PRIVACY PRACTICE: I acknowledge that I have read, understand, and agree to the CVHS "Notice of Privacy Practices"	
COLLECTIONS POLICY: I acknowledge that I have read, understand, and agree to the collections policy and my financial responsibility.	
INSURANCE: I authorize CVHS to release information related to my care to my insurance company. I assign insurance benefits to CVHS for all services rendered. I understand that I am financially responsible for all charges and that it is my responsibility to verify insurance coverage for services provided by CVHS and any specialists to whom I am referred.	

Please have your insurance card available at check in.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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