HealthWorks for Northern Virginia
Your Community Health Center
Quality Healthcare for All

Patient Registration Form

PATIENT INFORMATION (PLEASE PRINT)

Last Name: **First Name:** **Middle Name:**

Home Phone Number: ( )

Street Address:

Mobile Phone Number: ( )

City: **State:** **Zip Code:**

Are you Homeless? ❑ Yes ❑ No

Date of Birth: / /

Sex at Birth: ❑ M ❑ F

Marital Status
- ❑ Single, Widowed, Divorced
- ❑ Married
- ❑ Partner
- ❑ Separated

E-Mail Address ❑ Yes ❑ No

_____@_____

Social Security Number (optional):

_____ - _____ - _____

If Under the Age of 18, Parent or Guardian's Name:

Date of Birth: / /

Parent or Guardian Phone #: ( )

Parent or Guardian's Street Address (if different from patient address):

Advance Directive? ❑ Yes ❑ No

Parent or Guardian City:

Parent or Guardian State: **Parent or Guardian Zip Code:**

Preferred Way to Contact You:
❑ Cell Phone ❑ Home Phone
❑ Text ❑ E-Mail
❑ Patient Portal

PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Race: ❑ Black/African American ❑ Caucasian (White) ❑ Asian Indian ❑ Hawaiian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑ American Indian/Alaska Native ❑Vietnamese ❑Other Asian ❑Other Pacific Islander ❑ Guamanian or Chamorro ❑Samoan ❑ Declined to Specify

Preferred Language: ❑ English ❑ Spanish ❑ French ❑ Urdu ❑ Arabic ❑ Hindi ❑ Farsi ❑ Chinese ❑ Japanese ❑Slavic Languages ❑ Vietnamese ❑ Other African ❑ Italian ❑ Other

Ethnicity:
- ❑ Mexican American/Chicano
- ❑ Puerto Rican
- ❑ Cuban
- ❑ Another Hispanic/Latina(o) or a Spanish Origin
- ❑ Non-Hispanic/Latina(o)
- ❑ Choose not to disclose

Are you a seasonal worker ❑ Yes ❑No

Are you a migrant worker? ❑Yes ❑No

Do you need an interpreter? ❑ Yes ❑No

Are you in the military? ❑ Yes ❑ No

Are you a veteran? ❑ Yes ❑ No

Are you employed? ❑ Yes ❑ No

Are you employed? ❑ Full-time ❑ Part-time

Are you self-employed? ❑ Yes ❑ No

Are you a student? ❑ Yes ❑ No

Sexual Orientation:
- ❑ Lesbian
- ❑ Gay
- ❑ Heterosexual(Straight not Lesbian or Gay)
- ❑ Bisexual
- ❑ Something else
- ❑ Do not know
- ❑ Declined to specify
- ❑ Under the age of 18

Gender Identity:
- ❑ Male
- ❑ Female
- ❑ Transgender Male (Female to Male)
- ❑ Transgender Female (Male to Female)
- ❑ Other
- ❑ Declined to specify
- ❑ Under the age of 18

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EMERGENCY CONTACT (PERSON WE MAY CONTACT IN CASE OF EMERGENCY - OVER AGE 18)		
FULL NAME:	**RELATIONSHIP TO PATIENT:**	**CONTACT PHONE NUMBER:** ( )

HEALTH INSURANCE INFORMATION ❑ Yes ❑ No Health Insurance		
Subscriber Name:	Subscriber Number:	Subscriber Date of Birth: / /
Insurance Company:		
If Guarantor is different from the Guardian, Guarantor Name:		
If Guarantor is different from the Guardian, Guarantor Address:		

✓ **The above information is true to the best of my knowledge.**

Printed Name of Patient/Parent/Legal Guardian

Signature of Patient/Parent/Legal Guardian **Date**

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HealthWorks for Northern Virginia Policies and Consent

All patients are requested to read, initial, and comply with HealthWorks for Northern Virginia policies below. If you have any questions about our policies, please ask to speak with one of our Site Office Managers.

● Appointment Check In

Please check in 10 minutes before your appointment time. If you arrive after your appointment time, you may have to wait for the next available appointment.

Patient's Initials Here: _____

● Cancellation Policy

We will confirm your appointment by telephone, e mail, or text based on your preferred method of communication. If you need to cancel or reschedule an appointment, please call HealthWorks. In order to make space available for other patients who may need appointments, please cancel or reschedule as far in advance as possible.

Patient's Initials Here: _____

● Consent for Treatment

I authorize HealthWorks providers to perform and hereby consent to such treatment and examinations, including diagnostic procedures or evaluations and treatment, as may, in the opinion of the patient's provider, be necessary. This consent remains in effect as long as I receive care at HealthWorks or until I withdraw my consent.

Patient's Initials Here: _____

● HIV, Hepatitis B & C Testing

In the event that staff of HealthWorks comes in contact with my or my children's body fluids, I consent to be tested for HIV, Hepatitis B and C and Sexually Transmitted Infections.

Patient's Initials Here: _____

● Insurance & Billing Release

I hereby authorize my insurance benefits to be paid directly to the HealthWorks for Northern Virginia. I understand that I am personally responsible for all non-covered services, including services that my insurance company may deem unnecessary. I understand that I will receive an invoice for these charges and that unpaid invoices may be turned over to a collection agency.

Patient's Initials Here: _____