DIABETES HEALTH CENTER

A program of Community Health Trust

PATIENT REGISTRATION FORM

This information is used for statistical purposes and allows us to plan and improve our services.

Name: _____ Today's Date: _____

Address:_____

City: _____Zip code: _____ Email: _____

Home Phone: _____ Cell Phone:_____

Sex: ☐ M ☐ F ☐ X Age: _____ Date of Birth: _____

Marital Status: □ Single □Married □ Widow □ Divorced □ Separated

Emergency contact name: _____

Relationship: _____ Phone: _____

Family doctor or primary care provider: _____

Referred by: _____

Ethnic background (Please check all that apply):

☐ American Indian ☐ Black/African American ☐ Mexican American / Hispanic _____

□ Asian _____ ☐ White ☐ Filipino ☐ Other (describe) _____

What language do you usually speak? _____

What kind of work do you usually do? _____ Are you working now? ☐ Yes ☐ No

Employer: _____ Work phone: _____

Do you have medical insurance? ☐ No ☐ Yes Type: _____

Co-Payment? ☐ No ☐ Yes (If Yes) Amount _____ Member ID: _____

Insured Name: _____ Date of Birth: _____

The Diabetes Health Center will charge a fee of $10.00 for No-Show appointments or cancellation with less than 24-hour notice.
I give my permission for the DHC staff to receive and release information regarding my care to my health care providers and payers.

Patient's or Parent Signature_____ Date_____

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