Community Health Connections
We take great care of you!

New Patient Registration

Name: _____ **DOB:** _____

Social Security Number: _____

Address: _____ **Town/City:** _____

Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____ @ _____

If you are a minor (under 18 years old), who has legal custody of you?

☐ Mother* ☐ Father* ☐ Both Parents ☐ DCF* ☐ Legal Guardian*

Name (s): _____

**If both parents do not have legal custody, or someone else has temporary or permanent custody, we require proper legal documentation.*

What language do you prefer? To speak: _____ To write: _____

Do you need an interpreter? ☐ Yes ☐ No

Are you a Fitchburg State University student? ☐ Yes, live on campus ☐ Yes, live off campus ☐ No

Can we send you an activation email for a MyChart account? ☐ Yes ☐ No

*This is the fastest and easiest way to communicate with your providers, request medication refills, schedule appointments, get access to your health information and more. (*Used by all services except Dental)*

I would like to receive services at:

☐ **Fitchburg CHC** 326 Nichols Rd, Fitchburg	☐ **ACTION CHC** 130 Water St, Fitchburg	☐ **Greater Gardner CHC** 175 Connors St, Gardner	☐ **Leominster CHC** 165 Mill St, Leominster	☐ **South Gardner CHC** 529 Timpany Blvd, Gardner

I would like to receive:

☐ Medical	☐ Dental	☐ Behavioral Health	☐ Optometry
☐ Substance Use Services	☐ Podiatry	☐ Nutrition	☐ Acupuncture

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Guarantor: ☐ Self ☐ Someone else: Name: _____

Address: _____

Medical Insurance

Primary _____ ID: _____

Group #: _____

Subscriber: _____ ☐ Self

Subscriber DOB: _____

Secondary _____ ID: _____

Group #: _____

Subscriber: _____ ☐ Self

Subscriber DOB: _____

Vision Insurance

_____ ID: _____

Group #: _____

Subscriber: _____ ☐ Self

Subscriber DOB: _____

Dental Insurance

Primary _____ ID: _____

Group #: _____

Subscriber: _____ ☐ Self

Subscriber DOB: _____

Employer: _____

Secondary _____ ID: _____

Group #: _____

Subscriber: _____ ☐ Self

Subscriber DOB: _____

I have completed this form and certify that I am the patient or the duly authorized agent of the patient.

_____ _____

Signature Date

_____ _____

Printed Name Relationship

We are required, as a community health center, to collect data each year about the patients we serve. Your personal identity information (name and date of birth) is highly confidential and will not be included in the survey results or reported to any agency. (2025)

Name _____ Date of birth _____

What is your current gender identity? (Please check one):

☐ Female ☐ Male ☐ Transgender Male/Transgender Man/Transgender Masculine
☐ Other ☐ Chose not to disclose ☐ Transgender Female/Transgender Woman/Transgender Feminine

What sex were you assigned at birth on your original birth certificate? (Please check one):

☐ Female ☐ Male

Preferred pronouns (Please check one):

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs
☐ Patient's name ☐ Decline to answer ☐ Unknown ☐ Other: _____

Do you think of yourself as (Please check one):

☐ Heterosexual/straight ☐ Lesbian, gay or Homosexual ☐ Bisexual
☐ Something else ☐ Chose not to disclose ☐ I don't know

Which race(s) best represent you? (Check all that apply):

☐ Asian Indian ☐ Korean ☐ Other Pacific Islander ☐ American Indian/Alaska Native
☐ Chinese ☐ Vietnamese ☐ Guamanian or Chamorro ☐ White
☐ Filipino ☐ Other Asian ☐ Samoan ☐ Unreported
☐ Japanese ☐ Native Hawaiian ☐ Black/African American

Which ethnicity best represents you (Check all that apply):

☐ Cuban ☐ Mexican, Mexican American, Chicano/a ☐ Not Hispanic, Latino/a or Spanish Origin
☐ Puerto Rican ☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Unreported/Refused

Are you a Veteran? ☐ Yes ☐ No

How many family members are in your household? _____

What is your income? $ _____ ☐ Annually ☐ Monthly ☐ Weekly

What is your current housing status?

☐ Own or rent ☐ Homeless Shelter ☐ Permanent Supportive Housing
☐ Doubled up *(Living with others in a situation that is temporary and unstable)*
☐ Transitional Housing *(Extended, but temporary, housing used to transition from a homeless environment)*
☐ Street *(Living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy)*

Is your housing status: ☐ Section 8 ☐ Public Housing ☐ Not Public Housing

Are you a migrant worker?

☐ No
☐ Migratory Employed in the last 24 months, with temporary residence established for employment
☐ Seasonal Employed in the last 24 months, on a seasonal basis, without moving away from residence