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 and DOB: _____

Name and DOB: _____

**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 ☐ Urgent Care

☐ Substance Use Services ☐ Podiatry ☐ Nutrition ☐ Acupuncture

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

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Guarantor: ☐ Self ☐ Someone else: Name: _____

Address: _____

DOB: _____ Relationship: _____

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