MATTAPAN COMMUNITY HEALTH CENTER
1575 Blue Hill Avenue, Mattapan, MA 02126 | ph. 617-296-0061 | fax. 617-296-5408 | www.mattapanchc.org

PLEASE PRINT YOUR INFORMATION BELOW **MRN#**_____

PATIENT'S NAME on ID/Insurance (last, first, middle)	BIRTH DATE (mm/dd/yyyy)	AGE	Sex Listed on ID ☐ Female ☐ Male
ADDRESS			
CITY / STATE	ZIP CODE		
PREFFERED PHONE **TYPE** ☐ Mobile/Cell ☐ Home ☐ Work	ALTERNATE PHONE **TYPE** ☐ Mobile/Cell ☐ Home ☐ Work		
EMAIL	PARENT OR GUARDIAN'S NAME (if under age 18)		

How would you describe your gender?

- ☐ Female/Woman
- ☐ Male/Man
- ☐ Trans Woman or Trans Feminine
- ☐ Trans Man or Trans Masculine
- ☐ Nonbinary
- ☐ Genderqueer
- ☐ _____

What sex was listed on your first birth certificate?

- ☐ Female
- ☐ Male

How would you like our staff to refer to you?

First Name: _____

Pronouns: _____

What is your sexual orientation?

- ☐ Straight or heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Choose not to answer
- ☐ Don't know
- ☐ Bisexual
- ☐ Queer
- ☐ Pansexual
- ☐ _____

COUNTRY of BIRTH: _____

ETHNICITY

- ☐ Hispanic or Latino (specify: _____)
- ☐ Not Hispanic or Latino
- ☐ Choose not to answer
- ☐ Don't Know

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RACE

- ☐ Black/African American
- ☐ White
- ☐ American Indian
- ☐ Asian (specify: _____)
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other: _____
- ☐ Choose not to answer
- ☐ Don't know

I prefer to speak the following language:

- ☐ English
- ☐ Haitian Creole
- ☐ Spanish
- ☐ French
- ☐ Other:_____

I prefer to receive written communication in:

- ☐ English
- ☐ Haitian Creole
- ☐ Spanish
- ☐ French
- ☐ Other:_____

Are you blind or do you have serious difficulty seeing, even when wearing glasses?

□ Yes □ No

Are you deaf or do you have difficulty hearing?

□ Yes □ No

PATIENTS AGE 5 and OLDER:

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

□ Yes □ No

Do you have difficulty walking or climbing stairs?

□ Yes □ No

Do you have difficulty dressing or bathing?

□ Yes □ No

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

□ Yes □ No

SOCIAL SECURITY NUMBER	MARITAL STATUS	DO YOU HAVE HEALTH INSURANCE? ☐ Yes ☐ No
HEALTH INSURANCE COMPANY'S NAME		
POLICY NUMBER/MEMBER ID	SUBSCRIBER'S NAME AND RELATIONSHIP TO PATIENT	
DO YOU HAVE A SECOND HEALTH INSURANCE? ☐ Yes ☐ No	SECONDARY HEALTH INSURANCE NAME POLICY NUMBER/MEMBER ID	

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

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AUTHORIZATION AND CONSENT - ALL INFORMATION IS CONFIDENTIAL

1. **The undersigned herby authorizes physicians, surgeons, nurse practitioners, midwives, behavioral health staff, dentists, hygienists, dental assistants and physician assistants practicing at the Mattapan Community Health Center to furnish medical, dental, mental health, and minor surgical treatment as necessary and proper, including the administration of local anesthesia.**

2. **The undersigned hereby authorizes the release of such information as may be necessary, by the Mattapan Community Health Center, for the completion of insurance/billing forms.**

3. **I further agree to allow the Mattapan Community Health Center to share medical information with hospitals/health care facilities should I be referred for treatment.**

_____ _____

Signature of Patient, Parent, or legal guardian | Relationship

_____ _____

Signature of Witness | Date