



Welcome to LCHC

MR#

ADULT / BHS / FAMILY MEDICINE / METTA CENTER / PRENATAL / WOMEN SERVICES

In order to serve you promptly, we need the following information. Fill out each item or put not applicable (N/A).

For Office Use Only

Check here if N.P.P. is on file: Check here if consent form is on file:

Is the patient: New Established Original registration date: _____
(month/day/year)

Patient General Information

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip Code _____

Date of Birth : _____ Sex: Male Female Social Security # - -

(month/day/year)

Marital Status: Married Divorced Partner Separated Single Widow

Home Phone: _____ Ok to Call? Yes No Are You Homeless? Yes No

How do you describe yourself? (Check One Box)

White/ Non-Hispanic American Indian or Alaskan Native
 Black/ Non-Hispanic Don't Know
 Hispanic Other Specify: _____
 Asian/Pacific Islander

In what country were you born: _____ What language do you speak most often: _____

What is your ethnicity/ancestry?

African Central American Haitian Puerto Rican
 African American Chinese Laotian/Hmong White
 Brazilian Colombian Middle Eastern Don't Know
 Cambodian Dominican Other Asian _____ Other—Specify Below:
 Cape Verdean European Portuguese _____

Employment Information

Employment Status *(check one)*: Full Time Part Time Seasonal Migrant Unemployed Retired

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone: _____ Ok to Call? Yes No

Are you a Student? Yes No (If yes, please choose one) Full-Time Part-Time

Emergency Contact Information

Emergency Contact Name: _____ Emergency Phone Number: _____

Relationship to Patient: _____ Other Phone # (Cell, Pager, Etc.): _____

Insurance Information

Do you have Healthcare Coverage? *(Check one)*: Yes No

If you answered NO, would you like to speak to a financial counselor to apply for assistance? Yes No

Insurance Name: _____ Are you also insured by MassHealth / Medicaid? Yes No Applied

Relationship to Insured: Self Spouse Child Other Insurance Policy # _____

Subscriber's Name: _____ Address: _____

City/Town: _____ State: _____ Zip Code: _____