



Rev. 4/10/10

**THE GREATER HUDSON VALLEY  
Family Health Center, Inc.**

147 Lake Street, Newburgh, 12550  
(845) 563-8000 Fax: (845) 565-1364



**REGISTRATION FORM**

MR# \_\_\_\_\_

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(fecha)

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(paciente nombre) (fecha de nacimiento)

**Address:** \_\_\_\_\_  
(direccion)

**Telephone #:** \_\_\_\_\_ **work/trabajo**  
(# de telefono) (home/casa)

**Emergency Contact Name:** \_\_\_\_\_ **Telephone** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
(# de seguro social) (ocupacion)

**Sex:** [ ] M [ ] F **Marital Status:** \_\_\_\_\_ **Student:** [ ] YES [ ] NO **Family Size:** \_\_\_\_\_  
(sexo) (estado civil) (estudiante) (cuantos en la familia)

**Census Tract/ Ethnic Group (raza):** Hispanic or Latino [ ] YES [ ] NO [ ] Unreported/Refused to report  
Native Hawaiian: [ ] YES [ ] NO Other Pacific Islander [ ] YES [ ] NO [ ] Asian [ ] Black/African American  
[ ] American Indian/Alaska Native [ ] White [ ] More than one race [ ] Veteran [ ] Migrant [ ] Seasonal [ ] Homeless

**Coverage Information:** [ ] Insured [ ] Un-Insured - Weekly Salary (salario semanal): \$ \_\_\_\_\_ **SS Code:** \_\_\_\_\_

Medicaid# \_\_\_\_\_ Medicare# \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Insurance# \_\_\_\_\_  
(compania de seguro) (# del seguro)

Group# \_\_\_\_\_ Copay \$ \_\_\_\_\_ Effective: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(# de grupo del seguro) (efectivo)

Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(quien esta suscrito) (parentesco) (fecha de nacimiento)

Medicaid# \_\_\_\_\_ Medicare# \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Insurance# \_\_\_\_\_  
(compania de seguro) (# del seguro)  
Group# \_\_\_\_\_ Copay \$ \_\_\_\_\_ Effective: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(# de grupo del seguro) (efectivo)  
Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(quien esta suscrito) (parentesco) (fecha de nacimiento)

**Employer Name:** \_\_\_\_\_ **Employer Address** \_\_\_\_\_  
(Nombre de empleado) (direccion de empleado)

*I acknowledge the above information is correct and hereby authorize and request providers at The Greater Hudson Valley Family Health Center, Inc. to provide and bill for appropriate treatment. I understand that if my insurance coverage is terminated or inactive at the time of service, I will be responsible for the cost of the visit as a self pay patient. The Greater Hudson Valley Family Health Center has the right to ask for payment at the time services are rendered.*

[ ] I acknowledge that I have received a copy of the Patient Bill of Rights.

*Declaro que la informacion que he dado es correcta por medio de esta pido y autorizo al Greater Hudson Valley Family Health Center que me den el tratamiento apropiado y que cobren por el tratamiento. Entiendo que si mi seguro esta terminado o inactivo, you sere responsable por el costo de la visita como un paciente sin seguro medico. Greater Hudson Valley Family Health Center tiene el derecho de pedir el pago de la visita al momento de mi tratamiento.*

[ ] Certifico que he recibido copia de la Declaracion de los Derechos Del Paciente

Signature of Patient Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(firma del paciente/guardian) (relacion)