HEALTH CARE for THE HOMELESS

Edna Pilsbury
2222 Simon Bolivar Ave
N.O.L.A., 70113

CRRC
1530 Gravier St
N.O.L.A, 70112

Arthur Monday
1111 Newton St
N.O.L.A., 70114

Dental Patient Registration Form

Has the patient received services at HCH before? □ Yes □ No

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form*

LAST NAME	FIRST NAME	MIDDLE

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE	CELL PHONE

EMAIL ADDRESS

RELIGION:

MARITAL STATUS
□ Single □ Separated
□ Married □ Widowed
□ Domestic Partner □ Other
□ Significant Other

RACE
□ Black/ African American □ Asian
□ White □ Alaskan Native
□ Native Hawaiian □ Pacific Islander
□ American Indian □ Unknown
□ Multiple □ Choose not to disclose

Primary Language if Not English_____

Do You Need Interpretation Services? □ YES □ NO

Ethnicity/ Ethnic Orgin:
□ Hispanic □ Non- Hispanic

GENDER IDENTITY
□ Male
□ Female
□ Transgender Male (F to M)
□ Transgender Female (M to F)
□ Other
□ Non-binary/ genderqueer
□ Questioning
□ Other
□ Choose not to disclose

SEXUAL ORIENTATION
□ Straight or Heterosexual
□ Bisexual
□ Gay
□ Lesbian
□ Pansexual
□ Queer
□ Something else
□ Don't Know
□ Choose not to disclose

PRONOUNS
□ She/her/hers □ decline to answer
□ he/him/his □ unknown
□ they/them/theirs
□ ze/hir/hirs
□ ey/em/eirs
□ xe/xem/xyrs
□ ve/vir/vis
□ other
□ name

EMPLOYMENT STATUS
□ Not Employed
□ Full Time
□ Part Time
□ Retired
□ Active Duty
□ Self Employed
□ Student- Full Time
□ Student- Part Time
□ Unemployed due to disability

HOUSING STATUS □ Homeless □ At Risk for Homeless □ Currently not Homeless, was in last 12 months
□ Not homeless □ Living in Shelter □ Street, Camp, Bridge □ Living with Others □ Transitional Housing
□ Single Occupancy Hotel □ Permanent Supportive Housing □ Veteran At Risk For Homeless

Are you a U.S. Veteran?
□ Yes □ No

AGRICULTURAL WORKER
□ Migrant □ Seasonal
□ Neither

EMERGENCY CONTACT INFORMATION

NAME:_____ RELATIONSHIP TO PATIENT_____

PHONE: _____ STREET ADDRESS:_____

CITY_____STATE_____ZIP_____

Is the patient a minor? ☐ Yes ☐ No (If yes, please fill out parent / guardian information)

Guardian First Name:_____ Last Name: _____ MI_____

Social Security Number:_____ Phone Number:_____

Address: City State Zip

Insurance Information

□ **I currently have dental insurance** **Insurance Name:**_____
□ **I currently DO NOT have dental insurance**
□ **I would like to apply for Medicaid**
□ **I would like to apply for the SLIDING-FEE SCALE** **Policy/Id Number:**_____

Is this insurance □ Medicaid □ Medicare (If checked see next section)

Medicaid Information

Please select Medicaid Plan:
□ Aetna & Healthy Blue
□ United Healthcare
□ Louisiana Healthcare Connections
□ Amerihealth

Revised July 2020