Community Health & Wellness Center of Greater Torrington
469 Migeon Avenue, Torrington CT 06790 860-489-0931
115 Spencer Street, Winsted, CT 06098 860-238-4211

Please provide us with your Driver's License/Passport and all Insurance Cards

LAST NAME: _____ **FIRST:** _____ **M:** ____
Address: _____ **Apt #** _____
City: _____ **State:** _____ **Zip:** _____
Parent or Guardian's name, if patient is a minor _____
Gender Identity: Male __ Female __ Trans Man (FTM)___ Trans Woman (MTF) ___ Genderqueer____ Other Specify ____ Not Disclosed ___
Sexual Orientation: Straight ___ Gay or Lesbian ___ Bisexual ___ Other Specify ___ Unknown ____Not Disclosed _____
Marital Status: Married __ Single __ Divorced __ Widowed __ Separated: __ Unknown____
Social Security#_____ **Date of birth** ___/___/___ **PCP** _____
Home phone _____ Work Phone_____----**Cell phone**_____
Alternate phone _____
EMAIL ADDRESS: **How did you hear about us?**

ADDITIONAL PATIENT INFORMATION REQUIRED

Race: ___White ___Black ___Asian ___American Indian/Alaskan Native ___Pacific Islander ___Native Hawaiian ___Unknown
Ethnicity: ___Hispanic ___All others
Language: ___English ___Spanish ___Chinese ___Italian ___Japanese ___French ___Sign Language ___other
Veteran: ___Yes ___No

To receive federal funding and to continue to provide and increase services it is required that financial information is collected.

Family size: _____ **Total Household Annual Income: $** _____
Third Party Insurance _____
Agricultural: Seasonal Migrant Worker: __ __
Housing status: Homeless: __ Not Homeless: __ Shelter: __ Doubling Up: __ Transitional: __ Street: ____ other: __
Describe: _____
Are you a Diabetic: Yes___ No ____ **Do you have high blood pressure?** Yes ____ No ____
Insurance Co.: _____ Policy #: _____ Group#: _____
Effective date: _____ Name of Subscriber: _____
Relationship to insured _____ DOB_____ Co-pay $_____
Insured's Employer: _____ Work phone_____
Secondary (2nd) Insurance Co.: _____ Policy #: _____ Group #: _____
Effective date: _____ Name of Subscriber: _____
Relationship to insured: _____ DOB_____ Co-pay$_____
Emergency contact_____ Phone Number _____

Medical Authorization – Assignment of Benefits – Notice of Privacy Practices I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by Community Health & Wellness Center of Greater Torrington, Inc. I authorize the payment of any benefits due to Community Health & Wellness Center of Greater Torrington, Inc., and understand any co pays, referrals, new insurance information, deductibles and denied services will be patient's responsibility. I acknowledge that I have received a copy of Community Health & Wellness Center of Greater Torrington, Inc., Notice of Privacy Practices that describes how medical information about me may be used and disclosed. I authorize Community Health & Wellness Center to access my medical information including diagnostic and screening results from Charlotte Hungerford Hospital Meditech system. I understand that if I have any questions or complaints I may contact the Privacy Officer. I am also entitled to updates to these Privacy Practices.

- **I give consent for any type of procedure or treatment by all qualified personnel at CHWCGT, for the above named individual.**
- **We will be pulling from a database that monitors when and who last prescribed medications to you.**
- **I understand my patient responsibility regarding payment for the services I've received and will update new insurance information as needed**
- **As per our policy any services rendered offsite are the responsibility of the patient. CHWCGT will not be responsible for any of these charges. Example: lab, x-rays, specialty care, etc.**
- **HIV Testing**
- **I have read and understand the Notice of Privacy Practice**
- **I have received a copy of my patient rights and responsibilities and understand my rights and responsibilities as a patient.**

Patient Signature: _____Date:____/_____/_____
Guardian/POA/Conservator signature, if applicable _____
HIPPA given____ Date: ___/____/____
Please turn over and sign