Commonwealth Healthcare Corporation

COMMONWEALTH HEALTH CENTER

PATIENT REGISTRATION

Office Use Only - **CHC Chart #:** _____

Name: _____ (Last Name) _____ (First Name) _____ (Middle Name)

Date of Birth: ____ / ____ / ____ (Month / Day / Year) **Place of Birth:** _____ (City) _____ (State) **Gender:** ☐ Male ☐ Female

Social Security No.: _____ **EMAIL:** _____

Marital Status: (*Please Check Box*) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow **Religion:** _____

Address (P.O. Box): _____ **Street Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Village:** _____

Home Phone #: (_____) _____ **Cell Phone #:** (_____) _____

Employer: _____ **Work Phone:** (_____) _____

ETHNICITY BACKGROUND (*Please Circle*):

Bangladesh Carolinian Chamorro Chinese Caucasian Ponapean Palauan Yapese
Filipino Japanese Korean Nepal Chuukese Hispanic Other: _____

PARENTS - (*If patient below 17 years old and younger*)

Mother's Name: _____ (Maiden Name / First Name / Middle Name) **Employer:** _____ **Contact No.:** _____

Father's Full Name: _____ **Employer:** _____ **Contact No.:** _____

CLASSIFICATION: (Please Check Mark)

_____ **U.S. CITIZEN BORN IN CNMI** _____ **U.S. CITIZEN BORN OUTSIDE CNMI** _____ **U.S/CNMI RESIDENT** _____ **MICRONESIAN** _____ **BUSINESS PERMIT**
_____ **OTHERS** _____

_____ **NON-RESIDENT** (Contract Worker)**:** Passport No.:_____ Exp. Date: _____

Receipt CW No.: _____ Exp. Date: _____ Other Info: _____

_____ **DEPENDENT OF NON-RESIDENT** (Contract Worker): Passport No.:_____ Exp. Date: _____

VISA Control No.: _____ Exp. Date: _____ Status: _____

_____ **TOURIST:** Passport No.: _____ Exp. Date: _____

Name of Hotel: _____ Room No.: _____

EMERGENCY CONTACT INFORMATION

Name: _____ / _____ / _____ (Last Name / First Name / Middle Name) **Relationship to Patient:** _____

Address (P.O. Box): _____

City: _____ **State:** _____ **Zip Code:** _____ **Village:** _____ **Phone No. :** (_____) _____

NEXT OF KIN

Name: _____ / _____ / _____ (Last Name / First Name / Middle Name) **Relationship to Patient:** _____

Address (P.O. Box): _____

City: _____ **State:** _____ **Zip Code:** _____ **Village:** _____ **Phone No. :** (_____) _____

PRIMARY INSURANCE

Insurance Company: _____ Effective Date: _____

Subscriber:_____ Coverage: _____

Policy No.:_____ Group Number (if any): _____

SECONDARY INSURANCE

Insurance Company: _____ Effective Date: _____

Subscriber:_____ Coverage: _____

Policy No.:_____ Group Number (if any): _____

THE ABOVE STATEMENT ARE TRUE AND TO THE BEST OF MY KNOWLEDGE

PATIENT'S SIGNATURE: _____ **DATE:** _____