Organization RFCC Logo

Coordinating Centers

RFCC Logo

WOMEN'S SERVICES REGISTRATION FORM

PLEASE PRINT **TODAY'S DATE:** _____

Name:	Birth Date:	Phone (home):	Phone (work):
Mailing Address: City: State: Zip:			Email Address:

What is the best way to reach you? ❑ Telephone ❑ Mail ❑ Email	Reason for Contact:
Marital Status: ❑ Married ❑ Widowed ❑ Separated ❑ Never married ❑ Divorced ❑ Live with partner	Hispanic? ❑ Yes ❑ No ❑ White ❑ American Indian/Alaska Native ❑ Black/African American ❑ Multiracial ❑ Asian ❑ Unknown/Unreported ❑ Pacific Is./Hawaiian

Emergency and Follow-up Contact Information:

Name:	Phone (home):	Relationship
Address: City: State: Zip:		

People living in your household:

Name	Relationship to you	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you need transportation to medical or other health-related appointments? ❑ Yes ❑ No	Do you currently have health insurance? ❑ No ❑ Yes (If yes, check one)

Do you have difficulty paying for healthcare? ❑ Yes ❑ No	❑ Private ❑ Medicare ❑ Medicaid ❑ Other:_____

Highest Level of Education: ❑ Less than High School Graduate ❑ High School Graduate ❑ GED ❑ Some College ❑ College Degree or higher	Do you have a disability? ❑ Yes ❑ No If yes, what is your disability? _____	Are you currently pregnant? ❑ Yes ❑ No

Are you employed? ❑ Full-time ❑ Part-time ❑ Homemaker ❑ Self-employed ❑ Unemployed, laid off ❑ Unemployed, looking for work	What is your approximate family income per year? (before taxes) ❑ Under $ 20,000 ❑ $20,000 - $25,000 ❑ $25,001 – $30,000 ❑ $30,001 - $35,000 ❑ $35,001 - $40,000 ❑ $40,001 or more

Would you be interested in learning about the following services:

❑ Substance Abuse	❑ Healthy Lifestyles	❑ Parenting Classes
❑ Nutrition	❑ Tobacco Cessation	❑ Stress Management
❑ Family Abuse/Safety programs	❑ Transportation	❑ Prenatal health services
❑ Disease Management	❑ Other:_____	

Medical Services:

❑ Neurologist/neurosurgeon	❑ Cardiologist	❑ OB/GYN
❑ Treatment for skin - Dermatologist	❑ Cancer treatment -Oncologist	❑ Orthopedist
❑ Urologist	❑ Internal Medicine	❑ Family Medicine
❑ Counseling - Behavioral Health	❑ Pharmacy	❑ Radiologist
❑ Dentist	❑ Eye doctor - Ophthalmologist	❑ Pediatrician for my kids
❑ Other:_____		

Is there anything else we can help you with?_____

_____

For Office Use Only

Name of County Where Patient Resides:_____

County Designation: ❑ Urban ❑ Suburban ❑ Rural ❑ Frontier

RFCC Program Site: _____

Registration Form Completed By: ❑ Patient ❑ Provider/Staff

Registration information submitted via: ❑ Paper Form ❑ Telephone ❑ Website