

Patient Information**New Adult Patient Registration**

Last Name

First Name

Middle Initial

Preferred Name

Birth Date*Please give your ID card to the front desk*Sex: ☐ Male ☐ Female

Physical Address

Mailing Address (if different than physical)

City

State

ZIP Code

City

State

ZIP Code

Preferred LanguageWould an interpreter be helpful for your visit? ☐ Yes ☐ NoMy primary doctor is at CHC ☐ Yes ☐ No My primary dentist is at CHC ☐ Yes ☐ No**Patient Contact Information**

Home Phone ☐ Cell Phone

Alternate Phone

Email address*Preferred contact number: ☐ Home Phone ☐ Alternate PhoneYou have my permission to leave a detailed message on my preferred phone ☐ Yes ☐ NoHow would you like to receive appointment reminders? ☐ Email ☐ Phone call ☐ Text ☐ Voicemail

Emergency Contact Name

Relationship

Phone #**Patient Additional Demographics (UDS)**Are you homeless? ☐ Yes ☐ No Are you an Agricultural Worker? ☐ Yes ☐ No

What ethnicity do you consider yourself?

- ☐
- Cuban
- ☐
- Chicano/a
- ☐
- Mexican
-
- ☐
- Mexican American
- ☐
- Puerto Rican
- ☐
- Another Hispanic, Latino/a or Spanish origin
-
- ☐
- Not Hispanic, or Latino/a or Spanish origin
- ☐
- Prefer not to answer

What race do you consider yourself?

- ☐
- American Indian/Alaskan Native
- ☐
- Asian Indian
-
- ☐
- Black/African American
- ☐
- Chinese
- ☐
- Filipino
- ☐
- Guamanian or Chamorro
-
- ☐
- Hawaiian Native
- ☐
- Japanese
- ☐
- Korean
- ☐
- Other Asian
-
- ☐
- Other Pacific Islander
- ☐
- Samoan
- ☐
- Vietnamese
- ☐
- White
-
- ☐
- Prefer not to answer

Have you served in the United States military, armed forces or uniformed services? This includes: Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, or Reserves or the US Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA). ☐ Yes ☐ No

Primary pharmacy (name and location): _____

Secondary Pharmacy (name and address): _____

How Did You Hear About Us?

- ☐
- Tacoma/Pierce County Health Department
- ☐
- Needle Exchange Program
- ☐
- CHC Employee
-
- ☐
- Hospital—which one? _____
- ☐
- Outreach Worker
- ☐
- CHC Patient
-
- ☐
- Other: _____

Insurance Information

Please give your insurance card to the front desk.

Is there anyone you would like us to share your GENERAL* medical/dental information with?

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

****General information includes appointment times and dates, and that you are a patient at Community Health Care. It does NOT include reasons for appointments, results of testing or exams, or details about care.***

Authorization, Consent and Assignment of Benefits

I hereby consent to outpatient care with Community Health Care with a multidisciplinary team of clinicians. This care may include: Evaluation, Diagnostic, Consultation and Treatment for Medical, Psychiatric, Behavioral Health and/or Dental care. These services may be delivered in one of our clinics or through a telemedicine system, using video conferencing equipment. I authorize my insurance benefits to be paid directly to Community Health Care and understand that I am financially responsible for all non-covered services. I agree to the release of information regarding Treatment/Consultation for Medical, Psychiatric, Behavioral Health and/or Dental care for the purpose of payment or health care operations. I understand that Community Health Care will bill me and/or my insurance for in person, audio-visual, and audio-only medical, dental and/or behavioral health visits. This authorization and assignment is permanent and will remain on file and be used for future claims. I may revoke it at any time by written notice. I acknowledge that I have received a copy of the Notice of Privacy Practices for Community Health Care.

Signature: _____ Date: _____

Relationship to patient (if the patient has a guardian): _____

For Office Use Only:

Initials _____



Application For Sliding Fee

In order to meet the requirements of our Federal grant, we must collect income information on all patients. In order to qualify for sliding fee payments (for uninsured patients and those whose insurance may not pay for all services), you must fill out the information below.

If you are uninsured, you must also meet with a staff member to determine if you qualify for insurance before your second visit.

How many people are supported by this income? _____

Use the number of persons in your family who live in the same household and who share income, food and/or rent. That number includes you, your spouse, and/or any dependents. Please list the people you have included:

NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How much MONTHLY gross income in your household comes from:

Employment	_____	Disability	_____
Unemployment	_____	Pension Funds	_____
Social Security	_____	VA Benefits	_____
Spousal Support	_____	Public Assistance	_____
Scholarship/Grants	_____	Housing Allowance	_____
Military Family Allotments	_____	Other	_____

TOTAL MONTHLY INCOME \$ _____

To the best of my knowledge, the information given is true and correct. I give Community Health Care permission to verify information about my financial status. I understand that I must provide proof of this information by my next visit or within 30 days (whichever is first) in order to qualify for sliding fee scale. If this information is not received, then I will be billed at full fee for the visit.

_____	_____	_____
Patient or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date
_____	_____	_____
Patient or Parent/Guardian DOB	Patient or Parent/Guardian Signature (if applicable)	Date

For Office Use Only:			
Annual Income \$ _____	# in Household _____	Sliding Scale Level _____	Initials _____

Notice of Insurance Eligibility

Clinic: _____

Date: _____

Patient name: _____

DOB: _____

- ☐ Patient was not eligible for insurance (accept sliding fee per declaration on application and change sliding fee expiration date to 1 year from declaration)
- ☐ Patient eligibility is pending (patient has or is applying with Navigator; accept sliding fee per declaration on application and change sliding fee expiration to 1 month from date of declaration until eligibility determined); this can be extended for another month if insurance is still pending.
- ☐ Patient was eligible but chose not to accept insurance or meet with navigator (patient must bring in proof of income per policy: check stubs for past month, tax return, or other approved form)

I verify that I was offered insurance, but have refused.

Patient signature: _____

Date: _____

- ☐ Patient currently has insurance or is eligible and now has insurance (sliding fee per declaration on application; change sliding fee expiration date to 1 year from declaration)
- ☐ Unable to enroll patient; missed open enrollment, not eligible for (SEP) Special Enrollment Period (patient must bring in proof of income)
- ☐ Patient no showed or cancelled navigator appointment (patient must bring in proof of income)

Staff member signature: _____

Date: _____

Form is scanned into patient medical record.

Community Health Care**Dental Health History**

Date: _____ DOB: _____ Age: _____ Name: _____

Physician's name: _____ Physician's phone number: _____

Referred by: _____

Health History1. Are you in good health? ☐ Yes ☐ No

2. Date of your last physical examination:

3. Are you now under the care of a physician? ☐ Yes ☐ No

If so, what is the condition being treated?

4. Have you ever had any serious illness or operation? ☐ Yes ☐ No

If so, what illness or operation?

5. Have you ever been hospitalized? ☐ Yes ☐ No

If so, what was the problem?

6. Are you taking any drugs or medicines? ☐ Yes ☐ No

If so, what?

7. Are you sensitive or allergic to any drug or medicine? ☐ Yes ☐ No

If so, what?

8. Do you use tobacco products? ☐ Yes ☐ No

If so, what kind? _____ How much per day? _____

9. Do you have, or have you had, any of the following?

- | | | |
|--|---|--|
| ☐ Anemia | ☐ Blood diseases | ☐ Rheumatism or arthritis |
| ☐ Heart ailments | ☐ Hepatitis, jaundice or liver disease | ☐ Head injuries |
| ☐ High blood pressure | ☐ Kidney disease | ☐ Stomach ulcers |
| ☐ Respiratory disease | ☐ Tumors or growths | ☐ Venereal disease/STD |
| ☐ Tuberculosis | ☐ Radiation treatment of any kind | ☐ Epilepsy |
| ☐ Nervous disorders | ☐ Allergies | ☐ Mental disorders |
| ☐ Diabetes | ☐ Asthma | ☐ Stroke |
| ☐ Excessive bleeding | ☐ Fainting spells or seizures | ☐ HIV/AIDS |
| ☐ Rheumatic fever | ☐ Sinus trouble | ☐ Alcohol/drug abuse |
| ☐ Joint replacement (hip, knee, etc.) | | |

10. Have you ever been told you need to take medicine before you receive dental care? ☐ Yes ☐ No11. Do you wear a cardiac pacemaker? ☐ Yes ☐ No12. Have you had heart surgery? ☐ Yes ☐ No13. Do you have any other disease, condition or problem that you think I should know about? ☐ Yes ☐ No

If so, please explain:

14. How long since your last dental treatment?

15. Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No16. Have you had any unfavorable reactions to local anesthetic? ☐ Yes ☐ No17. Have you had abnormal bleeding associated with previous extractions? ☐ Yes ☐ No18. Do you have any unhealed sores or growths in or around your mouth? ☐ Yes ☐ No

19. How long since your last full-mouth X-ray?

20. (Women only) Are you pregnant? ☐ Yes ☐ No

If yes, when is your baby due?

Are you breastfeeding? ☐ Yes ☐ No

Authorization to Release/Obtain Confidential Medical/Dental Records

1. Patient Information:

Patient's legal name: _____

Previous names: _____

Date of birth: _____ SS#: _____ - _____ - _____

2. Information may be released FROM:

Name of provider or organization **RELEASING** information: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

3. Information may be released TO:

Name of person or organization **RECEIVING** information: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

OR

Email address: _____

4. What kind of information do you want released? (copy fees may apply)

☐ All records from last 2 years of **MEDICAL** visits ☐ All records from last 2 years of **DENTAL** visits

☐ All records from date ____ / ____ / ____ to ____ / ____ / ____

☐ Specific information (explain): _____

☐ Other (explain): _____

5. I specifically consent to the release of information that may be in my record relating to sexually transmitted diseases, mental health/psychiatric disorders, drugs and alcohol history and/or HIV/AIDS information unless I say otherwise below. I do **NOT** want the following information released:

6. Why are you asking for this information? (check ONE box)

☐ Doctor ☐ Lawyer ☐ Personal ☐ Insurance ☐ Other: _____

7. I understand that:

- Once information is released, it could be re-released by the person receiving it (if they are not a hospital, clinic, doctor, or health insurance company) and may no longer be protected under health information privacy laws.
- I have the right to cancel this authorization at any time by writing to CHC Medical Records. If I cancel my authorization, it will not affect any action already taken by CHC based on this authorization.
- CHC cannot condition treatment, payment, enrollment, or eligibility on whether I sign this authorization.

8. This authorization expires _____. If no date or event is specified, it expires 90 days from the date it is signed.

Signature: _____ Date: _____

Patient, parent, guardian, or authorized representative (documentation of authority to sign on behalf of patient may be required)

If not patient, relationship to patient: _____ Printed name: _____

Signature: _____ Date: _____

Minor Signature (REQUIRED if patient is 13-17 years old)