COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

Patient Information

Last Name	**First Name**	**Middle Initial**	**Social Security Number**
Address (mailing)			**Birth Date**
City	**State**	**Zip Code**	**Gender** ☐ Male ☐ Female ☐ I prefer not to answer
Address (billing, if different than mailing)			
City	State	Zip Code	**Marital Status** ☐ Married ☐ Widowed ☐ Single ☐ Divorced
Home Phone #	Daytime Phone #	**Preferred contact number:** ☐ Home phone ☐ Daytime phone	**Student Status** ☐ Full time ☐ Not a student ☐ Part time
Email address*		☐ You have my permission to leave a detailed message on preferred phone	**Veteran/Military** ☐ No ☐ Yes ☐ Active
How would you like to get appointment reminders? ☐ Email ☐ Phone call ☐ Text ☐ Voicemail		☐ I have a primary medical provider ☐ I have a dental provider	Preferred pharmacy:
Emergency Contact Name		**Emergency Contact Relationship to You**	**Emergency Contact Phone #**
What ethnicity do you consider yourself? ☐ Hispanic or Latino ☐ Not Hispanic/Latino	**What race do you consider yourself?** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian Native ☐ Other Pacific Islander ☐ White ☐ Other: ____________ ☐ I prefer not to answer		
Primary Language	**Interpreter needed?** ☐ Yes ☐ No	**If Homeless, Shelter Type** ☐ Street ☐ Transitional ☐ Other: ____________	☐ Doubling Up ☐ Shelter ☐ Unknown
For Agricultural Workers ☐ Seasonal ☐ Migrant	Employer	Employer Address/Phone	

Responsible Party Information (if different than above) ☐ Same as above

Last Name	**First Name**	**Middle Initial**	**Social Security Number**
Address (mailing)			**Birth Date**
City	**State**	**Zip Code**	**Gender** ☐ Male ☐ Female ☐ I prefer not to answer
Address (billing, if different than mailing)			
City	State	Zip Code	**Marital Status** ☐ Married ☐ Widowed ☐ Single ☐ Divorced
Home Phone #	Daytime Phone #	**Preferred:** ☐ Home phone ☐ Daytime phone	**Student Status** ☐ Full time ☐ Not a student ☐ Part time
Email address*			**Veteran/Military** ☐ No ☐ Yes ☐ Active

*****Community Health Care will not sell or rent your email address, name, mailing address, or other supplied information to anyone. Community Health Care will not share your email address, first or last name, mailing address, or other received information with anyone, except: we may disclose personally identifiable information about you as legally required in order for us to respond to subpoenas, court orders, or other legal processes.*

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Responsible Party Information (continued)			
What ethnicity do you consider yourself? ☐ Hispanic or Latino ☐ Not Hispanic/Latino	**What race do you consider yourself?** ☐ American Indian/Alaskan Native ☐ Hawaiian Native ☐ Other: ______	☐ Asian ☐ Other Pacific Islander	☐ Black/African American ☐ White ☐ I prefer not to answer
Primary Language	**If Homeless, Shelter Type** ☐ Transitional	☐ Doubling Up ☐ Shelter ☐ Other: ______	☐ Street ☐ Unknown
For Agricultural Workers ☐ Seasonal ☐ Migrant	Employer	Employer Address/Phone	

Primary Insurance Information	
Name of Insurance Company	**PLEASE GIVE INSURANCE CARD TO FRONT DESK TO MAKE A COPY**

If Related to Auto Accident, Please Provide Information Below			
Name of Insurance Company	Policy ID Number	Group Number	Effective Date
Insurance Claims Address			Accident Date
Policy Holder Name		Birth Date	Relationship to patient

How Did You Hear About Us?			
☐ Billboard	☐ Tacoma/Pierce Co. Health Dept.	☐ CHC Employee	☐ Website
☐ Community event	☐ Yellow Pages	☐ Needle Exchange Program	☐ Outreach Worker
☐ Hospital—which one? ______		☐ Other: ______	

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. 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.

Is there anyone you would like us to share your general medical information with?

Name: ______ Relationship: ______ Phone number: ______

Name: ______ Relationship: ______ Phone number: ______

Name: ______ Relationship: ______ Phone number: ______

Signature: ______ **Date:** ______

Relationship to patient (if the patient is a minor or has a guardian): ______

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), <u>you must fill out the information below</u>.

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 __________

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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 History

1. 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 or hay fever	☐ Stroke
☐ Excessive bleeding	☐ Fainting spells or seizures	☐ HIV/AIDS
☐ Rheumatic fever	☐ Sinus trouble	☐ Alcohol/drug abuse
☐ Joint replacement (hip, knee, etc.)		

10. Do you wear a cardiac pacemaker? ☐ Yes ☐ No
11. Have you had heart surgery? ☐ Yes ☐ No
12. Have you ever been told you need to take medicine before you receive dental care? ☐ Yes ☐ No
13. Do you have any other disease, condition or problem that you think I should know about? ☐ Yes ☐ No
    If so, please explain: ________________________________
14. (Women only) Are you pregnant? ☐ Yes ☐ No
    If yes, when is your baby due? ______________
    Are you breastfeeding? ☐ Yes ☐ No
15. How long since your last dental treatment? ______________
16. Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No
17. Have you had any unfavorable reactions to local anesthetic? ☐ Yes ☐ No
18. Have you had abnormal bleeding associated with previous extractions? ☐ Yes ☐ No
19. Do you have any unhealed sores or growths in or around your mouth? ☐ Yes ☐ No
20. How long since your last full-mouth X-ray? ______________

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)