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)			**Marital Status** ☐ Married ☐ Widowed ☐ Single ☐ Divorced
City	State	Zip Code	

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** ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional ☐ Other: _____ ☐ Unknown
For Agricultural Workers ☐ Seasonal ☐ Migrant	Employer	Employer Address/Phone

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

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Address (billing, if different than mailing)			**Marital Status** ☐ Married ☐ Widowed ☐ Single ☐ Divorced
City	State	Zip Code	

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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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 _____

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MEDICAL • DENTAL • PHARMACY

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

Confidential Adolescent Health Inventory

(13 - 18 Yrs.)

Please complete both sides

Date: _____ **DOB:** _____ **Age:** ____ **Name:** _____

Please bring in a record of your immunizations for us to copy.

Please ask your healthcare provider about any questions you do not understand

What do you like to be called? _____

Who lives in your household? (Name, relationship, age) _____

_____

Where do you go to school? _____

What grade are you in? _____ What are your average grades? _____

History

List any health problems you have or had previously: _____

_____

List current medicines or skin products you are using, including over-the-counter/herbal medicines: _____

_____

Are you allergic to any medicines, food or other things? ..... ☐ Yes ☐ No

If yes, list what they are and the reaction(s): _____

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

For what? _____

Nutrition

List the things you have eaten in the past 24 hours: _____

_____

List the number of servings you have of these foods any day: ____ bread/pasta __ milk ___ meat __ vegetables ____fruit

Mark the number of meals you eat each day: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you use laxatives or vomit (throw up) to keep your weight down? ..... ☐ Yes ☐ No

Dental

Do you brush your teeth daily? ..... ☐ Yes ☐ No

Do you floss your teeth daily? ..... ☐ Yes ☐ No

Do you visit a dentist at least once a year? ..... ☐ Yes ☐ No

Safety

Do you wear a seat belt in the car? ..... ☐ Yes ☐ No

Do you wear a bicycle and/or motorcycle helmet when you ride? ..... ☐ Yes ☐ No

Do you have a smoke alarm in your home? ..... ☐ Yes ☐ No

Do you have a fire extinguisher in your home? ..... ☐ Yes ☐ No

Do you know how to swim? ..... ☐ Yes ☐ No

Are your immunizations (shots) up to date? ..... ☐ Don't know ☐ Yes ☐ No

Check any of the following that bother you:

☐ your weight	☐ concussion	☐ pneumonia	☐ bedwetting
☐ your height	☐ blurred vision	☐ bronchitis	☐ fractures (broken bones)
☐ trouble sleeping	☐ headaches	☐ hay fever	☐ sports injuries
☐ nightmares	☐ ear aches	☐ constipation	☐ back aches
☐ allergies	☐ hearing loss	☐ diarrhea	☐ painful bones or joints
☐ skin rash	☐ nose bleeds	☐ stomach aches	☐ depression
☐ insect bite/sting reaction	☐ cold sores	☐ nausea	☐ school problems
☐ dizzy spells	☐ chest pain	☐ bleeding from your bottom	☐ family problems
☐ fainting	☐ trouble breathing	☐ leaking from your vagina	☐ need a counselor
☐ convulsions	☐ wheezing	☐ leaking from your penis	
☐ unconsciousness (knocked out)	☐ asthma	☐ bloody urine	

Immunizations

Were you born in a foreign country? ..... ☐ Yes ☐ No

Have you had close contact with a person infected with TB, or been in jail or a long-term care facility? ..... ☐ Yes ☐ No

(OVER)

Sexuality

What best describes your sexual orientation? ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Other ☐ Don't Know ☐ Prefer not to answer

Have you ever had intercourse (sex)? ☐ Yes ☐ No

What method of birth control did (or do) you use? _____

Did (or do) you use condoms? ☐ Yes ☐ No

Do you want information about pregnancy or birth control? ☐ Yes ☐ No

Do you want information about sexually transmitted diseases? ☐ Yes ☐ No

Do you think you have ever been exposed to or been treated for an STD (venereal disease)? ☐ Yes ☐ No

Do you know what STD (venereal disease) symptoms are? ☐ Yes ☐ No

Social

Do you usually expect to succeed in things you do? ☐ Yes ☐ No

Do you feel you are liked by most people who know you? ☐ Yes ☐ No

Do you feel you get along with your parents? ☐ Yes ☐ No

Within the last 12 months, have you been in a relationship in which there were threats, pushing, grabbing, hitting, kicking, breaking things or other hurting used? ☐ Yes ☐ No

Within the last 12 months, have you experienced any uncomfortable touching? Forced sexual contacts? Abuse? ☐ Yes ☐ No

Do you find it hard to concentrate on a task or job? ☐ Yes ☐ No

Have you ever thought about suicide? ☐ Yes ☐ No

Do you worry about any other person close to you, such as friends or relatives? ☐ Yes ☐ No

Do you want to hurt or cut yourself? ☐ Yes ☐ No

Moods

How often do you find yourself bothered by any of these moods?

	seldom	occasionally	often
anger	☐	☐	☐
boredom	☐	☐	☐
depression	☐	☐	☐
frustration	☐	☐	☐
loneliness	☐	☐	☐
shyness	☐	☐	☐
stressed out	☐	☐	☐

Health Risks

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many per day? _____

Do you smoke marijuana? ☐ Yes ☐ No

Do you use chewing tobacco or snuff? ☐ Yes ☐ No

Do you use cocaine or crack? ☐ Yes ☐ No

Do you use speed/meth/crank? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

Do you sniff glue or other aerosols? ☐ Yes ☐ No

Family History

Check any of the following problems your parents, brothers, sisters, grandparents, aunts, uncles, or cousins have had, and say who:

	WHO		WHO
☐ alcoholism	_____	☐ diabetes	_____
☐ allergies	_____	☐ drug problem	_____
☐ asthma	_____	☐ heart disease	_____
☐ blood disease	_____	☐ high blood pressure	_____
☐ cancer	_____	☐ overweight	_____
☐ child abuse	_____	☐ suicide	_____
☐ convulsions	_____	☐ tuberculosis	_____
☐ depression	_____	☐ any inherited disease	_____

Girls Only

How old were you when your periods started? _____

Do you have any problems with your periods? ☐ Yes ☐ No

Do you have irregular periods? ☐ Yes ☐ No

Do you have cramps? ☐ Yes ☐ No

Do you take medicine for your periods? ☐ Yes ☐ No

Do you have breast lumps or discharge from your nipples? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

Have you ever had an abortion? ☐ Yes ☐ No

Boys Only

Have you had any lumps in your testicles? ☐ Yes ☐ No

Have you ever made someone pregnant? ☐ Yes ☐ No

For official use only

Reviewed by: _____

Date: _____

Authorization to Release/Obtain Confidential Medical/Dental Records

COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

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)