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

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:** ☐ 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 ☐ Asian ☐ Black/African American ☐ Hawaiian Native ☐ Other Pacific Islander ☐ White ☐ Other: _____ ☐ I prefer not to answer		
Primary Language	**If Homeless, Shelter Type** ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional ☐ Other: _____ ☐ 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): _____

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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 _____

COMMUNITY HEALTH Care
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 Adult Health Inventory
Please complete both sides

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

Are you allergic to any drug/medicine? ☐ Yes ☐ No To a food/other substance? ☐ Yes ☐ No
If yes, list medicine and/or food/substance and describe reaction(s): _____

_____

Current Medications: (include any over-the-counter medicines, vitamins, and herbal supplements)
Please bring your medications with you to your next appointment if you did not bring them today.

_____ _____
_____ _____
_____ _____
_____ _____

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

Past Medical History: Have you been diagnosed with any of the following?

Yes
- ☐ Anemia
- ☐ Chest pain/angina
- ☐ Anxiety/panic disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood Clots
- ☐ Cancer (type : _____)
- ☐ COPD or emphysema
- ☐ Depression
- ☐ Diabetes

Yes
- ☐ High cholesterol/Elevated lipids
- ☐ Gallbladder disease
- ☐ GERD/reflux
- ☐ Severe headaches, migraines
- ☐ Heart disease
- ☐ Liver problem
- ☐ High blood pressure/Hypertension
- ☐ Heart attack/Myocardial infarction
- ☐ Kidney problems/renal disease
- ☐ Stroke
- ☐ Thyroid problems

Surgery/Serious Injury/Hospitalization (include year)

_____ _____
_____ _____
_____ _____
_____ _____

When was your last colonoscopy or colon cancer screening? _____

Men Only: Have you had any of the following?

Yes	No		Yes	No	
☐	☐	Prostate problems	☐	☐	Penis/testicle problems
☐	☐	Have you ever had a sexually transmitted disease? Which one? _____			

Women Only: Have you had any of the following?

Yes	No		Yes	No	
☐	☐	Problems with uterus/tubes/ovaries	☐	☐	Irregular periods
☐	☐	Hysterectomy	☐	☐	Spotting/bleeding between periods
☐	☐	An abnormal Pap smear	Date of last Pap smear: _____		
☐	☐	Breast problems (lump/discharge)	Date of last mammogram: _____		
☐	☐	A bone (DEXA) scan	Date of last bone scan: _____		
☐	☐	A sexually transmitted disease	Which one? _____		

How many have you had of each of the following? Pregnancies _____ Miscarriages _____ Live Births _____ Abortions _____
Present birth control method: _____

(over)

Family History: Include parents, sister, brothers, aunts, uncles, grandparents (*blood relatives only*).

Has any family member had:	**Father**		**Mother**		**Brother/Sister**		**Other Relative**		
Condition	Has	Onset Age	Has	Onset Age	Has	Onset Age	Has	Relative	Onset Age
ADD/ADHD	☐		☐		☐		☐		
Alcoholism	☐		☐		☐		☐		
Cancer (type:)	☐		☐		☐		☐		
Cancer (type:)	☐		☐		☐		☐		
Cancer (type:)	☐		☐		☐		☐		
Heart attack/disease	☐		☐		☐		☐		
Depression	☐		☐		☐		☐		
Diabetes	☐		☐		☐		☐		
High cholesterol	☐		☐		☐		☐		
Genetic disease (like sickle cell):	☐		☐		☐		☐		
High blood pressure	☐		☐		☐		☐		
Migraines	☐		☐		☐		☐		
Stroke	☐		☐		☐		☐		
Thyroid disorder	☐		☐		☐		☐		
Other:	☐		☐		☐		☐		

Social History:

Yes	**No**		**Describe**
☐	☐	Tobacco (type, amount per day)	
☐	☐	Alcohol (what kind, how often)	
☐	☐	Caffeine beverages (what kind, cups/cans per day)	
☐	☐	Are you foreign born? If yes, where	
☐	☐	Trouble sleeping? (hours you sleep per night)	
☐	☐	Do you agree to blood transfusion/products?	
☐	☐	Do you have cultural or religious beliefs that affect your medical care?	
☐	☐	Do you regularly use seat belts?	
☐	☐	Do you have a smoke alarm?	

Confidential Social History:

Do you use recreational drugs? If yes, what type? _____

How often? _____ How do you take them? _____

What was your sex assigned at birth? ☐ Male ☐ Female

What is your gender now? ☐ Male ☐ Female ☐ Transgender Female-to-Male
☐ Transgender Male-to-Female ☐ Other ☐ I prefer not to answer

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

Authorization to Release/Obtain Confidential Medical/Dental Records

COMMUNITY HEALTH Care
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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)