

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

Responsible Party Information (continued)			
What ethnicity do you consider yourself? <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic/Latino	What race do you consider yourself? <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Other: _____ <input type="checkbox"/> White <input type="checkbox"/> I prefer not to answer		
Primary Language	If Homeless, Shelter Type <input type="checkbox"/> Doubling Up <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
For Agricultural Workers <input type="checkbox"/> Seasonal <input type="checkbox"/> 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?			
<input type="checkbox"/> Billboard	<input type="checkbox"/> Tacoma/Pierce Co. Health Dept.	<input type="checkbox"/> CHC Employee	<input type="checkbox"/> Website
<input type="checkbox"/> Community event	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Needle Exchange Program	<input type="checkbox"/> Outreach Worker
<input type="checkbox"/> Hospital—which one? _____		<input type="checkbox"/> 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), 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.

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

Please bring in a record of your child's vaccinations for us to copy

Concerns

1. Do you have any particular concerns about your child? _____

2. Has your child had a tuberculosis (TB) skin test? Yes No
If yes, date _____
a. Was your child born in another country?
b. Has your child had close contact with a TB-infectious person?

Development

At what age did your child:

smile or respond to smile _____ Not Yet
roll over _____
sit alone _____
crawl _____
take 10 steps alone _____
join words _____
potty train—pee _____
potty train—poop _____
(girls) have her first period _____ N/A

Social

3. Who lives with your child? (name, relationship, age) _____
4. Do you think your child is in any way different from other children his/her age?
If yes, in what way? _____

Does your child:

5. Have trouble getting along with teachers in school?
6. Have trouble learning?
7. Need extra help in math or reading?
8. Have trouble getting along with other children?
9. Has your child shown aggressive verbal, physical or sexual behavior?
10. Within the last 12 months, has your child been in a relationship with threats, pushing, grabbing, hitting, kicking, breaking things, or other hurting?
11. Circle any of the following that describes your child:

Nutrition

12. List what your child has had to eat and drink in the past 24 hours:
13. List the number of servings your child has of these foods each day:
14. How many meals does your child eat each day?
15. Is your child a fussy eater?
16. Does your child eat too much?
17. Do you give vitamins or iron?
18. Is or was your child on WIC?

Health History

19. Has your child ever been hospitalized?
If yes, explain and give dates:
20. List any health problems/surgeries your child has had:
21. List any medicines your child is currently taking, including over-the-counter and herbal medicines:
22. List any food/medicine your child is allergic to:
23. Circle any of the following that apply to your child: anemia, allergies, seizures, heart murmur, joint pain, shortness of breath, night time cough, snores, mouth breather, frequent sore throats, frequent colds, frequent vomiting, wets/dirties pants, wets bed, frequent diarrhea, severe constipation, overactive, ignores parents, eyes cross or wander, trouble hearing, speech difficulty

Dental

24. Does your child take fluoride drops or tablets or use fluoridated water?
25. Do your child's teeth get brushed daily?
26. Are your child's teeth flossed daily?
27. Does your child visit the dentist at least once a year?

Family History

28. Circle any of the following problems that members of the child's family have had: any inherited disease, allergies, asthma, blood disease, cancer, convulsions, depression, diabetes, heart disease, high blood pressure, heart attack at a young age, high cholesterol, overweight, tuberculosis, suicide, alcoholism, drug abuse, child abuse, physical abuse, sexual abuse

Safety

29. Does your child use an age-appropriate car seat and/or seat belt?

Car seats should face the back of the car until your child is at least 2 years old. Washington State law requires all children to ride in an appropriate car seat or booster seat until they are 4'9" tall (RCW 46.61.687). The back seat of cars is the safest place for children 12 years old and younger to ride.

30. Do you have a properly working smoke detector in your home?
31. Do you know how to help your child if he/she is choking?
32. If your child rides a bicycle, does he/she use an approved bike helmet to prevent head injury?
33. Have you taught your child about personal safety and what to do if someone bothers or attempts to molest him/her?

For official use only
Reviewed by: _____ Date: _____

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)