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** ☐ 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)			
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?	**What race do you consider yourself?**		
☐ Hispanic or Latino ☐ Not Hispanic/Latino	☐ 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 ☐ Other: ____________	☐ Shelter ☐ 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 **Infant Health Inventory** (Birth – 1 Yr.)

Date: ______________ **DOB:** ______________ **Name:** ____

Concerns

1. Do you have any particular concerns about your baby?

____

____

Prenatal and Birth History

2. Birth weight ______________ birth length____________
3. Was your baby early or late? ☐ Early ☐ Late ☐ No

   If yes, how many weeks? _________
4. Was your baby born at home? ☐ Yes ☐ No
5. Mother's age at the time of this pregnancy? __________
6. # of pregnancies: ________ # of living children: ________
7. Month prenatal care was started:____________________

At any time during this pregnancy:	**Yes**	**No**
8. Did you have bleeding?	☐	☐
9. Did you have flu or other infections?	☐	☐
10. Did you have persistent vomiting?	☐	☐
11. Did you need drugs other than vitamins or iron?	☐	☐
12. Did you have high blood pressure?	☐	☐
13. Did you have other illness or accidents?	☐	☐
14. Were you or your doctor worried about this pregnancy?	☐	☐
15. Did you use alcohol or street drugs?	☐	☐
16. Were you on WIC?	☐	☐
17. How long was the labor? _______________		
18. Were there any difficulties with labor?	☐	☐

If yes, explain: ____________________________________

____

Health History

19. Please ***circle*** any of the following that happened to your baby during the first two weeks after delivery:

blue spells	colic	cried a lot
infections	jaundice	jittery/shaky
longer hospital stay	mother depressed	
problems breathing	trouble feeding	

Explain anything you circled above:____________________

____

____

20. List any medicines your baby is currently taking, including over-the-counter and herbal medicines:

____

21. List any foods/medicines your baby is allergic to:

____

Social

22. Who lives with your baby? (name, relationship, age)

____

____

23. Do you think your baby is in any way different from other children his/her age? ☐ Yes ☐ No

    If yes, in what way? ________________________________
24. Do you worry about your baby's safety? ☐ Yes ☐ No
25. ***Circle*** any of the following that describe your baby:

doesn't eat well	good child	happy child
have to spank	irritable	trouble sleeping

Development

If your baby is ***2 months old or older***, at what age did he/she:

		Not Yet
smile or respond to smile	____________________	☐
roll over	____________________	☐
sit alone	____________________	☐
crawl	____________________	☐
take 10 steps alone	____________________	☐
join words	____________________	☐

Nutrition

26. What do you feed your baby? (mark all that you use):

    ☐ Breastmilk ☐ Formula

    ☐ Other (explain): ______________________________
27. If you breastfeed, about how many times does your baby nurse in 24 hours? How long each time?

    ☐ ____ times for _______minutes ☐ Don't breastfeed
28. If you use formula, about how many ounces of formula does your baby drink in 24 hours?

    ☐ ______ ounces ☐ Don't use formula
29. What other food does your baby eat, and how much of each in 24 hours? ________________________________

    ____

	Yes	**No**
30. Does your baby eat too much?	☐	☐
31. Do you give vitamins or iron?	☐	☐
32. Is your baby on WIC?	☐	☐

Dental

	Yes	**No**
33. Does your baby take fluoride drops or use fluoridated water? ☐ Don't know	☐	☐
34. Do you ever prop a bottle for your baby?	☐	☐

Family History

35. ***Circle*** any of the following problems that members of your baby'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

	Yes	**No**
36. Does your baby use a rear-facing infant car seat?	☐	☐

Your baby's car seat should face the back of the car until your baby 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.

37. Do you have a smoke detector in your home that works properly?	☐	☐
38. Do you know how to help your baby if he or she is choking?	☐	☐

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)