

Patient Information

Last Name

First Name

Middle Initial

Preferred Name

Social Security Number

Birth Date

Gender Assigned at Birth: Male Female Undifferentiated

Current Legal Gender: Male Female Undifferentiated

Gender Identity: Prefer not to answer Male Female
 Male-to-Female Female-to-Male Other: _____

Sexual Orientation: Prefer not to answer Straight Lesbian/gay Bisexual
 Other: _____

Preferred Pronoun: Prefer not to answer He/Him/His She/Her/Hers
 They/Them/Theirs Ze/Hir Other: _____

Physical Address

Mailing Address (if different than physical)

City **State** **ZIP Code** **City** **State** **ZIP Code**

Marital Status: Widowed Married Single Divorced

Student Status: Full time Not a student Part time

Would an interpreter be helpful for your visit? Yes No

Primary Language

I have a primary medical provider **I have a primary dental provider**

Patient Contact Information

Home Phone

Daytime Phone

Email address*

Preferred contact number: Home Phone Daytime Phone
 You have my permission to leave a detailed message on my preferred phone

How would you like to receive appointment reminders? Email Phone call Text Voicemail

Emergency Contact Name

Relationship

Phone #

Patient Additional Demographics (UDS)

If homeless, shelter type: Doubling up Shelter Street Transitional
 Other: _____ Unknown

For Agricultural Workers: Seasonal Migrant

What ethnicity do you consider yourself? Hispanic or Latino
 Not Hispanic or Latino

What race do you consider yourself? American Indian/Alaskan Native Asian
 Black/African American Hawaiian Native
 Other Pacific Islander White
 Other: _____ Prefer not to answer

Veteran/Military Status: Yes No Active

What is your preferred pharmacy? (name and location) _____

**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.*

Primary Insurance Information**Auto Accident?****On-the-Job Injury?**

Name of insurance company

Date of accident

Claim number or date of injury

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

Last Name

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Middle Initial

Preferred Name

Social Security Number

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 Prefer not to answer Male Female

Current Legal Gender:

 Male Female

Gender Identity:

 Prefer not to answer Male Female
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Marital Status: Widowed Married Single DivorcedStudent Status: Full time Not a student Part timeWould an interpreter be helpful for your visit? Yes No

Primary Language

 I have a primary medical provider I have a primary dental provider**Responsible Party Information Contact Information**

Home Phone

Daytime Phone

Email address*

Preferred contact number: Home Phone Daytime Phone You have my permission to leave a detailed message on my preferred phoneHow would you like to receive appointment reminders? Email Phone call Text Voicemail

Emergency Contact Name

Relationship

Phone #

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 Other Pacific Islander White
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How Did You Hear About Us?

- Tacoma/Pierce County Health Department Needle Exchange Program CHC Employee
 Hospital—which one? _____ Outreach Worker CHC Patient
 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.

- I understand that Community Health Care will bill me and/or my insurance for in person, audio-visual, and audio-only medical, dental and/or behavioral health visits.

Is there anyone you would like us to share your **general** medical/dental 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): _____

For Office Use Only:

- Patient Declined Sliding Fee and Income Range Declaration Patient Portal enrollment information given Initials _____



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:** _____

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

- Prostate problems
- Have you ever had a sexually transmitted disease? Which one? _____

Yes No

- Penis/testicle problems

Women Only: Have you had any of the following?

Yes No

- Problems with uterus/tubes/ovaries
- Hysterectomy
- An abnormal Pap smear
- Breast problems (lump/discharge)
- A bone (DEXA) scan
- A sexually transmitted disease

Yes No

- Irregular periods
- Spotting/bleeding between periods

Date of last Pap smear: _____

Date of last mammogram: _____

Date of last bone scan: _____

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:

Condition	Father		Mother		Brother/Sister		Other Relative	
	Has	Onset Age	Has	Onset Age	Has	Onset Age	Has	Relative
ADD/ADHD	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Alcoholism	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Cancer (type: _____) ..	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Cancer (type: _____) ..	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Cancer (type: _____) ..	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Heart attack/disease	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Depression.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Diabetes.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Genetic disease (like sickle cell):.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

High blood pressure.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Thyroid disorder.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Other:.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

Social History:

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



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)