

**Patient Information****Annual Adult Patient Registration**

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Initial \_\_\_\_\_

Preferred Name \_\_\_\_\_

*Please give your ID to the front desk*

Birth Date \_\_\_\_\_

Physical Address \_\_\_\_\_

Mailing Address (if different than physical) \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP Code \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP Code \_\_\_\_\_

My primary **doctor** is at CHC  Yes  NoMy primary **dentist** is at CHC  Yes  No**Patient Contact Information**Home Phone  Cell Phone

Alternate Phone \_\_\_\_\_

Email address\* \_\_\_\_\_

Preferred contact number:  Home Phone  Alternate PhoneYou have my permission to leave a detailed message on my preferred phone  Yes  NoHow would you like to receive appointment reminders?  Email  Phone call  Text  Voicemail

Emergency Contact Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone # \_\_\_\_\_

**Patient Additional Demographics (UDS)**Are you homeless?  Yes  NoAre you an Agricultural Worker?  Yes  NoHave you served in the United States military, armed forces or uniformed services? This includes: Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, or Reserves or the US Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA).  Yes  No

What is your preferred pharmacy? (name and location): \_\_\_\_\_

**Primary Insurance Information***Please give your insurance card to the front desk.***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: \_\_\_\_\_

**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. 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. 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.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**For Office Use Only:**

Initials \_\_\_\_\_