Patient Information — Minor Annual Patient Registration Form

Last Name ____ First Name ____ Middle Initial ____ Preferred Name ____

Birth Date ____

Please give your ID card to the front desk

Physical Address ____

Mailing Address (if different than physical) ____

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

City ____ State ____ ZIP Code ____

My **primary doctor is at CHC** ☐ Yes ☐ No

My **primary dentist is at CHC** ☐ Yes ☐ No

Patient Contact Information

Home Phone ☐ Cell Phone ____ **Alternate Phone** ____ **Email address*** ____

Preferred contact number: ☐ Home Phone ☐ Alternate Phone

You have my permission to leave a detailed message on my preferred phone ☐ **Yes** ☐ **No**

How 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 ☐ No

Are you an Agricultural Worker? ☐ Yes ☐ No

Have 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):____

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: ____

***General Medical/Dental Information doesn't include: treatment, diagnosis, results of testing, other sensitive health information or reproductive information. For this information you need to sign a release of records.**

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: ____

Printed Name: ____ Relationship to patient: ____

For Office Use Only: Initials ______

Responsible Party Information

Last Name **First Name** **Middle Initial** **Preferred Name**

Please give your ID card to the front desk

Birth Date

Sex: ☐ Male ☐ Female

Physical Address Mailing Address (if different than physical)

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

Preferred Language **Would an interpreter be helpful for your visit?** ☐ Yes ☐ No

Responsible Party Contact Information

Home Phone ☐ Cell Phone **Alternate Phone** **Email address**

Preferred contact number: ☐ Home Phone ☐ Alternate Phone

You have my permission to leave a detailed message on my preferred phone ☐ **Yes** ☐ **No**

Emergency Contact Name **Relationship** **Phone #**

Responsible Party Additional Demographics (UDS)

Are you homeless? ☐ Yes ☐ No **Are you an Agricultural Worker?** ☐ Yes ☐ No

What ethnicity do you consider yourself? ☐ Cuban ☐ Chicano/a ☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Another Hispanic, Latino/a or Spanish origin ☐ Not Hispanic, or Latino/a or Spanish origin ☐ Prefer not to answer

What race do you consider yourself? ☐ American Indian/Alaskan Native ☐ Asian Indian
☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro
☐ Hawaiian Native ☐ Japanese ☐ Korean ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White
☐ Prefer not to answer

Have 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

Signature: ______________________ Date: ____________

Printed Name: ______________________ Relationship to patient: ____________