Patient Information — New Adult Patient Registration

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

Birth Date ____

Please give your ID card to the front desk

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

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

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

Primary pharmacy (name and location): ____

Secondary Pharmacy (name and address)**:** ____

How Did You Hear About Us?

☐ Tacoma/Pierce County Health Department
☐ Needle Exchange Program
☐ CHC Employee
☐ Hospital—which one?____
☐ Outreach Worker
☐ CHC Patient
☐ Other: ____

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 information includes appointment times and dates, and that you are a patient at Community Health Care. It does NOT include reasons for appointments, results of testing or exams, or details about care.

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: ___________________

Relationship to patient (if the patient has a guardian): ____

For Office Use Only:

Initials ________