

Patient Information**New Minor Patient Registration Form**_____
Last Name_____
First Name_____
Middle Initial_____
Preferred Name*Please give your ID to the front desk*_____
Birth DateSex: Male Female_____
Physical Address_____
Mailing Address (if different than physical)_____
City_____
State_____
ZIP Code_____
City_____
State_____
ZIP Code_____
Preferred LanguageWould an interpreter be helpful for your visit? Yes NoMy 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 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 location) _____

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: _____

Printed Name: _____ Relationship to patient: _____

For Office Use Only:

Initials _____

Responsible Party Information

Last Name

First Name

Middle Initial

Preferred Name

Birth Date

Sex: Male Female

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

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: _____