Community Health Care, Inc.

# PATIENT INFORMATION

MRN #: _____

## Patient Information – Demographics

**First Name**: _____**Middle Initial**: ____ **Last Name**: _____ **Preferred Name**: _____

**Date of Birth**: (Month)_____/(Date)_____/ (Year)_____ Social Security #: _____

**Legal sex**? ☐Female ☐Male ☐Nonbinary ☐X ☐Unknown

**Mailing Address**: _____ **Apt./Lot#**_____ **City**: _____**State**: _____ **Zip Code**: _____

**Primary Phone Number**: _____ ☐Home ☐Mobile

**Alternative Phone Number:** _____☐Home ☐Mobile

**Email Address:** _____

**Emergency Contact Name**: _____ **Relationship to patient**: _____ **Phone Number:** _____

**Preferred Language**? ☐English ☐Spanish ☐Vietnamese ☐Swahili ☐French ☐Haka Chin ☐ Arabic ☐Burmese ☐Karen ☐ Pashto ☐ Other: _____

## UDS Questions

1. **Are you a Migrant Worker/farm Worker**: ☐Yes ☐No? If yes; ☐Migrant or ☐Seasonal
2. **Are you Homeless:** ☐Yes ☐No?
3. **What race do you consider yourself?** ☐Black/ African American ☐White ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Guamanian or Chamorro ☐Samoan ☐Native American ☐ Alaska Native ☐Unreported/Choose not to disclose race
4. **What ethnicity do you consider yourself?** ☐Not Hispanic ☐Mexican, Mexican American, Chicano/o ☐Puerto Rican ☐Cuban ☐Another Hispanic, Latino/a or Spanish origin, Latino/a, or Spanish origin ☐Unreported/ Choose not to disclose ethnicity
5. **Are you a U.SA. Veteran/Military:** ☐Yes ☐No?

## Insurance and Billing Information

**Do you have insurance?** ☐Yes ☐No **If Yes, what type**: ☐Private Insurance ☐Medicaid ☐Medicare
Primary Medical Insurance:_____ Dental Insurance:_____

**If you have Private Insurance, please fill in the Insurance Policy holder information below <u>if NOT patient.</u>**

Insurance Policy holder Name: _____ DOB: _____Social Security #_____

Mailing Address: _____ Apt./Lot #_____ City: _____ State: _____ Zip Code: _____

## Detailed Message Consent

I give Community Health Care my consent to leave detailed information on voice messages and/or send detailed text messages. This may include lab results, test results, form/records information, and medication information. This **<u>WILL NOT</u>** include mental health, substance use, sexually transmitted diseases, genetic testing, and HIV information. We will need to speak to you directly about this type of information.

☐ Yes
☐ No

**It is your responsibility to ensure we have your most current phone number on record.**

**Please mark your choice to participate in receiving detailed voice messages and text messages.**

## Treatment/ Financial Agreement: I AGREE TO THE FOLLOWING

- The above information I provided is true.
- I agree to pay for care provided to me
- I understand that I am responsible to pay all required co-pays up front before seeing the provider
- I give my permission to release of health/financial information that is needed to conduct audits and/ or process insurance claims including: HIV, mental health, STDs, genetic testing, and drug abuse.
- I agree to notify CHC Immediately should there be a change in demographics, income, insurance coverage, etc.

**PATIENT SIGNATURE/ PARENT/GUARDIAN OR RESPONSIBLE PARTY:** _____

Relationship to Patient (if not patient): _____ **Date:**_____