

Patient Information

Last Name

First Name

Middle Initial

Preferred Name

Social Security Number

Birth Date

Gender Assigned at Birth:

- Male Female Undifferentiated

Current Legal Gender:

- Male Female Undifferentiated

Gender Identity:

- Prefer not to answer Male Female
 Male-to-Female Female-to-Male Other: _____

Sexual Orientation:

- Prefer not to answer Straight Lesbian/gay Bisexual
 Other: _____

Preferred Pronoun:

- Prefer not to answer He/Him/His She/Her/Hers
 They/Them/Theirs Ze/Hir Other: _____

Physical Address

Mailing Address (if different than physical)

City

State

ZIP Code

City

State

ZIP Code

Marital Status: Widowed Married Single Divorced

Student Status: Full time Not a student Part time

Would an interpreter be helpful for your visit? Yes No

Primary Language

- I have a primary medical provider I have a primary dental provider

Patient Contact Information

Home Phone

Daytime Phone

Email address*

Preferred contact number:

- Home Phone Daytime Phone
 You have my permission to leave a detailed message on my preferred phone

How would you like to receive appointment reminders? Email Phone call Text Voicemail

Emergency Contact Name

Relationship

Phone #

Patient Additional Demographics (UDS)

If homeless, shelter type:

- Doubling up Shelter Street Transitional
 Other: _____ Unknown

For Agricultural Workers:

- Seasonal Migrant

What ethnicity do you consider yourself?

- Hispanic or Latino
 Not Hispanic or Latino

What race do you consider yourself?

- American Indian/Alaskan Native Asian
 Black/African American Hawaiian Native
 Other Pacific Islander White
 Other: _____ Prefer not to answer

Veteran/Military Status:

- Yes No Active

What is your preferred pharmacy? (name and location) _____

*Community Health Care will not sell or rent your email address, name, mailing address, or other supplied information to anyone. Community Health Care will not share your email address, first or last name, mailing address, or other received information with anyone, except: we may disclose personally identifiable information about you as legally required in order for us to respond to subpoenas, court orders, or other legal processes.

Responsible Party Information (if different than above) Same as above**Last Name****First Name****Middle Initial****Preferred Name****Social Security Number****Birth Date****Gender Assigned at Birth:**

-
- Prefer not to answer
-
- Male
-
- Female

Current Legal Gender:

-
- Male
-
- Female

Gender Identity:

-
- Prefer not to answer
-
- Male
-
- Female
-
-
- Male-to-Female
-
- Female-to-Male
-
- Other: _____

Sexual Orientation:

-
- Prefer not to answer
-
- Straight
-
- Lesbian/gay
-
-
- Bisexual
-
- Other: _____

Preferred Pronoun:

-
- Prefer not to answer
-
- He/Him/His
-
- She/Her/Hers
-
-
- They/Them/Theirs
-
- Ze/Hir
-
- Other: _____

Physical Address**Mailing Address (if different than physical)****City****State****ZIP Code****City****State****ZIP Code****Marital Status:** Widowed Married Single Divorced**Student Status:** Full time Not a student Part time**Would an interpreter be helpful for your visit?** Yes No**Primary Language**

-
- I have a primary medical provider**
-
- I have a primary dental provider**

Responsible Party Information Contact Information**Home Phone****Daytime Phone****Email address*****Preferred contact number:** Home Phone Daytime Phone **You have my permission to leave a detailed message on my preferred phone****How would you like to receive appointment reminders?** Email Phone call Text Voicemail**Emergency Contact Name****Relationship****Phone #****Responsible Party Additional Demographics (UDS)****If homeless, shelter type:** Doubling up Shelter Street Transitional
 Other: _____ Unknown**For Agricultural Workers:** Seasonal Migrant**What ethnicity do you consider yourself?** Hispanic or Latino
 Not Hispanic or Latino**What race do you consider yourself?** American Indian/Alaskan Native Asian
 Black/African American Hawaiian Native
 Other Pacific Islander White
 Other: _____ Prefer not to answer**Veteran/Military Status:** Yes No Active**How Did You Hear About Us?**

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

Primary Insurance Information**Auto Accident?****On-the-Job Injury?**

Name of Insurance Company _____

Policy ID Number _____

Group Number _____

Insurance claims Address _____

Effective Date _____

Policy Holder Name _____

Birth Date _____

Relationship to Patient _____

 Accident? Yes No
 Work Auto

Date of accident _____

Claim number or date of injury _____

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. 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.

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.

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: _____

Signature: _____ Date: _____

Relationship to patient (if the patient is a minor or has a guardian): _____

For Office Use Only: Patient Declined Sliding Fee Patient Declined Sliding Fee and Income Range Declaration Patient Portal enrollment information given

Initials _____

Application For Sliding Fee

In order to meet the requirements of our Federal grant, we must collect income information on all patients. In order to qualify for sliding fee payments (for uninsured patients and those whose insurance may not pay for all services), you must fill out the information below.

If you are uninsured, you must also meet with a staff member to determine if you qualify for insurance before your second visit.

How many people are supported by this income? _____

Use the number of persons in your family who live in the same household and who share income, food and/or rent. That number includes you, your spouse, and/or any dependents. Please list the people you have included:

NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU

How much MONTHLY gross income in your household comes from:

Employment _____	Disability _____
Unemployment _____	Pension Funds _____
Social Security _____	VA Benefits _____
Spousal Support _____	Public Assistance _____
Scholarship/Grants _____	Housing Allowance _____
Military Family Allotments _____	Other _____

TOTAL MONTHLY INCOME \$ _____

To the best of my knowledge, the information given is true and correct. I give Community Health Care permission to verify information about my financial status. I understand that I must provide proof of this information by my next visit or within 30 days (whichever is first) in order to qualify for sliding fee scale. If this information is not received, then I will be billed at full fee for the visit.

Patient or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date
Patient or Parent/Guardian DOB	Staff member signature	Date

For Office Use Only:

See child's chart

Annual Income \$ _____ # in Household _____ Sliding Scale Level _____ Initials _____

Insurance eligibility:

- Patient was not eligible for insurance (accept sliding fee per declaration on application and change sliding fee expiration date to 1 year from declaration)
- Patient eligibility is pending (patient has or is applying with Navigator; accept sliding fee per declaration on application and change sliding fee expiration to 1 month from date of declaration until eligibility determined); this can be extended for another month if insurance is still pending.
- Patient was eligible but chose not to accept insurance or meet with navigator (patient must bring in proof of income per policy: check stubs for past month, tax return, or other approved form)
- Patient currently has insurance or is eligible and now has insurance (sliding fee per declaration on application; change sliding fee expiration date to 1 year from declaration)
- Patient no showed or cancelled navigator appointment, was unable to enroll due to enrollment period, or chose not to accept navigator appointment (patient must bring in proof of income)

(Form is scanned into patient record)

Date: _____ DOB: _____ Age: _____ Name: _____

Gender preference: Male Female Other: _____ Preferred Name: _____

Preferred Pronoun: _____

****Please bring in a record of your immunizations for us to copy. ****

Please ask your healthcare provider about any questions you do not understand

Personal Medical History

Yes No Do you have any particular concerns today about your child today? If yes, please explain: _____

Yes No Does your child have any ongoing major medical illnesses (like asthma, diabetes, etc.?) If yes, what? _____

Yes No Does your child take any medicines (daily or as needed)? What? _____

Yes No Does your child take any vitamins, supplements, "alternative" medicines, or therapies? What? _____

Yes No Does your child have any reactions to medicines or immunization? If yes, please explain: _____

Yes No Has your child ever had a surgery or had to spend the night at the hospital? If yes, please explain: _____

Family History

Unknown/Adopted

Check any of the following problems your parents, brothers, sisters, or other children have had, and state who:

Who?

Who?

Blood disease: _____

Heart attack: _____

Depression: _____

Overweight: _____

High blood pressure: _____

Alcoholism: _____

High cholesterol: _____

Physical abuse: _____

Suicide: _____

Asthma: _____

Child abuse: _____

Convulsions: _____

Allergies: _____

Tuberculosis: _____

Cancer: _____

Drug abuse: _____

Diabetes: _____

Sexual abuse: _____

Preventive Health

Yes No

- Does your child use an age-appropriate care seat and/seat belt?
- Does your child always use a helmet when riding a bike, skateboarding, skiing, etc.?
- Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
- Does anyone living with your child smoke?
- Does your child get more than 2 hours of recreational screen time a day (computer, TV, tablets)?
- Has your child seen a dentist in the past 6 months?
- Does your child brush his/her/their teeth daily?
- Has your child been in close contact with anyone who has tuberculosis (TB), or is at high risk for TB (anyone who has lived in a developing country, been institutionalized, homeless, IV drug user, HIV-positive)?

Education

Where does your child go to school? _____ What grade are they in? _____

What are their average grades? _____

Yes No Does your child have an Individualized Education Plan (IEP)/504 In place?

Social

Yes No

- Within the last 12 months, has your child been exposed to a situation where threats, pushing, grabbing, hitting, kicking, breaking things or other hurting has been used?
- Within the last 12 months, has your child experienced any uncomfortable touching? Forced sexual contacts?
- Who does your child live with? _____
- Has your child ever been on foster care?

Review of Systems (Does your child have any CURRENT problems that you'd like to discuss today?)

Yes No

What?

Yes No

What?

- | | |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> vision problems _____ | <input type="checkbox"/> <input type="checkbox"/> skin problems _____ |
| <input type="checkbox"/> <input type="checkbox"/> breathing problems _____ | <input type="checkbox"/> <input type="checkbox"/> hearing problems _____ |
| <input type="checkbox"/> <input type="checkbox"/> problems with bowel movements (pooping) _____ | <input type="checkbox"/> <input type="checkbox"/> headaches, fainting, dizziness, any loss of consciousness _____ |
| <input type="checkbox"/> <input type="checkbox"/> stomach problems _____ | <input type="checkbox"/> <input type="checkbox"/> sleep difficulties, depression, anger, or nervousness _____ |
| <input type="checkbox"/> <input type="checkbox"/> problems urinating (peeing) _____ | |
| <input type="checkbox"/> <input type="checkbox"/> body aches _____ | |

Females Only

Yes No Menstrual irregularities, pain, or concerns about your child's periods? _____

Males Only

Yes No Issues with your child's testicles or penis? _____

Other concerns: _____

For official use only

Reviewed by: _____

Date: _____

(over)

Authorization to Release/Obtain Confidential Medical/Dental Records



1. Patient Information:

Patient's legal name: _____

Previous names: _____

Date of birth: _____ **SS#:** _____ - _____ - _____

2. Information may be released **FROM:**

Name of provider or organization RELEASING information: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ Fax #: _____

3. Information may be released **TO:**

Name of person or organization RECEIVING information: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ Fax #: _____

OR

Email address: _____

4. **What kind of information do you want released?** (copy fees may apply)

All records from last 2 years of **MEDICAL** visits All records from last 2 years of **DENTAL** visits

All records from date ____ / ____ / ____ to ____ / ____ / ____

Specific information (explain): _____

Other (explain): _____

5. I specifically consent to the release of information that may be in my record relating to sexually transmitted diseases, mental health/psychiatric disorders, drugs and alcohol history and/or HIV/AIDS information unless I say otherwise below. I do **NOT** want the following information released:

6. **Why are you asking for this information?** (check ONE box)

Doctor Lawyer Personal Insurance Other: _____

7. I understand that:

- Once information is released, it could be re-released by the person receiving it (if they are not a hospital, clinic, doctor, or health insurance company) and may no longer be protected under health information privacy laws.
- I have the right to cancel this authorization at any time by writing to CHC Medical Records. If I cancel my authorization, it will not affect any action already taken by CHC based on this authorization.
- CHC cannot condition treatment, payment, enrollment, or eligibility on whether I sign this authorization.

8. This authorization expires _____ . If no date or event is specified, it expires 90 days from the date it is signed.

Signature: _____ **Date:** _____

Patient, parent, guardian, or authorized representative (documentation of authority to sign on behalf of patient may be required)

If not patient, relationship to patient: _____ Printed name: _____

Signature: _____ Date: _____

Minor Signature (REQUIRED if patient is 13-17 years old)