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

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

☐ **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.*

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

Name of insurance company _____ Date of accident _____ Claim number or date of injury _____

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

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

☐ **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 #** _____

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☐ 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: _____

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 and Income Range Declaration ☐ Patient Portal enrollment information given Initials_____

COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

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	Patient or Parent/Guardian Signature (if applicable)	Date

For Office Use Only:

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

COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

Notice of Insurance Eligibility

Clinic: _____

Date: _____

Patient name: _____ DOB: _____

☐ 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)

I verify that I was offered insurance, but have refused.

Patient signature: _____ **Date:** _____

☐ 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)

☐ Unable to enroll patient; missed open enrollment, not eligible for (SEP) Special Enrollment Period (patient must bring in proof of income)

☐ Patient no showed or cancelled navigator appointment (patient must bring in proof of income)

Staff member signature: _____ Date: _____

Form is scanned into patient medical record.

Community Health Care **Dental Health History**

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

Physician's name: _____ Physician's phone number: _____

Referred by: _____

Health History

1. Are you in good health? ☐ Yes ☐ No
2. Date of your last physical examination: .....
3. Are you now under the care of a physician? ☐ Yes ☐ No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ☐ Yes ☐ No
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ☐ Yes ☐ No
   If so, what was the problem? _____
6. Are you taking any drugs or medicines? ☐ Yes ☐ No
   If so, what? _____
7. Are you sensitive or allergic to any drug or medicine? ☐ Yes ☐ No
   If so, what? _____
8. Do you use tobacco products? ☐ Yes ☐ No
   If so, what kind? _____ How much per day? _____
9. Do you have, or have you had, any of the following?

☐ Anemia	☐ Blood diseases	☐ Rheumatism or arthritis
☐ Heart ailments	☐ Hepatitis, jaundice or liver disease	☐ Head injuries
☐ High blood pressure	☐ Kidney disease	☐ Stomach ulcers
☐ Respiratory disease	☐ Tumors or growths	☐ Venereal disease/STD
☐ Tuberculosis	☐ Radiation treatment of any kind	☐ Epilepsy
☐ Nervous disorders	☐ Allergies	☐ Mental disorders
☐ Diabetes	☐ Asthma	☐ Stroke
☐ Excessive bleeding	☐ Fainting spells or seizures	☐ HIV/AIDS
☐ Rheumatic fever	☐ Sinus trouble	☐ Alcohol/drug abuse
☐ Joint replacement (hip, knee, etc.)		

10. Have you ever been told you need to take medicine before you receive dental care? ☐ Yes ☐ No
11. Do you wear a cardiac pacemaker? ☐ Yes ☐ No
12. Have you had heart surgery? ☐ Yes ☐ No
13. Do you have any other disease, condition or problem that you think I should know about? ☐ Yes ☐ No
    If so, please explain: _____
14. How long since your last dental treatment? _____
15. Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No
16. Have you had any unfavorable reactions to local anesthetic? ☐ Yes ☐ No
17. Have you had abnormal bleeding associated with previous extractions? ☐ Yes ☐ No
18. Do you have any unhealed sores or growths in or around your mouth? ☐ Yes ☐ No
19. How long since your last full-mouth X-ray? _____
20. (Women only) Are you pregnant? ☐ Yes ☐ No
    If yes, when is your baby due? _____
    Are you breastfeeding? ☐ Yes ☐ No

Authorization to Release/Obtain Confidential Medical/Dental Records

COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

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)