Patient Information — Adult Annual Registration Form

Legal Last Name _____ **Legal First Name** _____ **(MI)** ____ **Preferred/Nickname** _____

Birth Date _____

Please hand your ID card to the receptionist.

Physical Address _____ Mailing Address (if different than physical) _____

City _____ **State** _____ **ZIP Code** _____ City _____ State _____ ZIP Code _____

Is your primary Medical provider at CHC? ☐ **Yes** ☐ **No** **Is your primary Dental provider at CHC?** ☐ **Yes** ☐ **No**

Patient Contact Information

Primary Phone ☐ Cell _____ **Alternate Phone** _____ **Email** _____

Preferred contact number: ☐ Primary phone ☐ Alternate phone

☐ You have my permission to leave a detailed message on preferred phone

☐ You have my permission to send detailed letter to my mailing address

How would you like to get 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

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). ☐ No ☐ Yes

Preferred Pharmacy (name and address):_____

Primary 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 Medical/Dental Information doesn't include; treatment, diagnosis, results of testing, other sensitive health information or reproductive information, for this consent you need a release of records.**

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.

Signature: _____ Date:_____

For Office Use Only: **Initials** _____