Patient Information — New Minor Registration Form

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

Social Security ☐ **Declined** _____ **Birth Date** _____ **Gender Assigned at Birth:** ☐ Male ☐ Female

Current 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 _____

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

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

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). ☐ No ☐ Yes

Primary Pharmacy (name and address):_____

Secondary Pharmacy (name and address):_____

How Did You Hear About Us?

☐ Tacoma/Pierce Co. Health Dept.
☐ Hospital—which one? _____
☐ Other:_____
☐ Needle Exchange Program
☐ Outreach Worker
☐ CHC Employee
☐ CHC Patient

Primary Insurance Information

_____
Name of Insurance Company

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:_____

Printed Name: _____ Relationship to the patient : _____

For Office Use Only: **Initials** _____

Responsible Party Information

Legal Last Name | **Legal First Name** | **(MI)** | **Preferred/Nickname**

Please give your ID card to the front desk

Social Security ☐ **Declined** | **Birth Date**

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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

Would an interpreter be helpful for your visit? ☐ Yes ☐ No

Preferred Language

Responsible Party 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

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Signature:_____ Date:_____

Printed Name: _____ Relationship to the patient : _____