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| PATIENT INFORMATION | | | | | | | | | |
| ❑ Mr. ❑ Mrs. Last name: First: Middle:  ❑ Ms. ❑ Miss | | | | | | | | | |
| Social Security#: | | | | | Birth date:  / / | | | Age: | Sex: ❑ M  ❑ F |
| Street address: Unit/Apt/Suite/Floor: | | | | | | | | | |
| P.O. Box: | City: | | | | | | State: | ZIP Code: | |
| Race: Check All That Apply ❑ American Indian/Alaskan Native ❑ Asian  ❑ Black/African American ❑ Pacific Islander ❑ Multi-racial ❑ Native Hawaiian ❑ Other Pacific Islander ❑ White ❑Other \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Preferred Language:  ❑ English ❑ Spanish  ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Ethnicity:  ❑ Hispanic\Latino  ❑ Non Hispanic\Latino | Marital status  ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Widowed | | | Are you a student:  ❑ Yes ❑ No | |  | | | |
| Primary Telephone#: ❑ Home ❑ Cell ❑ Work  Secondary Telephone#: ❑ Home ❑ Cell ❑ Work | | | | | | | | | |
| Occupation: | Employer Name: ❑ Full Time ❑ Part Time | | | | | | Employer phone #:  ( ) | | |
| By providing your email address, you agree to receive CHS updates and notifications:  Email Address: | | | | | | | | | |
| responsible party (COMPLETE ONLY IF DIFFERENT FROM PATIENT) | | | | | | | | | |
| Name: | | Address : | | | | | | | |
| Birth date: / / | | | | | Home Phone #: ( ) | | | | |
| Occupation: | Employer: | | | | Employer address: | | | | |
| Employer Phone #:  ( ) | | Migrant Farm Worker?  ❑ Yes ❑ No | | | | | Social Security #:` | | |
| Emergency Contact  Name: | | | Relationship to patient: | | | | Home phone #:  ( ) | | |
| Because we are a federally-qualifed community health center, we are required to report data about the basic financial information of our patients. This information is confidential. | | | | | | | | | |
| Homeless:  ❑ Yes ❑ No  ❑ Shelter ❑ Transitional  ❑ Street ❑ Doubled up | Migrant Worker:  ❑ Yes  ❑ No  ❑ Seasonal | | Veteran:  ❑Yes  ❑ No | | # of people in household \_\_\_\_\_\_  Approximate Household  Annual Gross Income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Insurance Information | | | | | | | | | |
| (Please give insurance card(s) to the receptionist) | | | | | | | | | |
| Name of Primary Insurance: | | | Policy Number #: | | | | Group: | | |
| Subscriber Name: | | | | | Patient’s Relationship to Subscriber:  ❑ Self ❑Spouse ❑ Child ❑ Other | | | | |
| Name of Secondary Insurance(If Applicable): | | | Policy Number #: | | | | Group #: | | |
| Subscriber Name: | | | | | Patient’s Relationship to Subscriber:  ❑ Self ❑Spouse ❑ Child ❑ Other | | | | |
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