Health First Community Health Center

PLEASE PRINT

PATIENT INFORMATION

Last Name_____
First Name_____
Previous Name_____
Physical Address_____
Mailing Address_____
City_____
State_____ Zip Code_____
Home Number(_____)_____
Cell Number (_____)_____
Work Number (_____)_____
Email Address_____

I want my medical provider to be_____
Date of Birth (mm/dd/yyyy)_____
Sex ☐ Male ☐ Female

Marital Status

☐ Single ☐ Married ☐ Divorced
☐ Partner ☐ Legally Separated ☐ Widowed

Social Security Number_____
Employer Name_____
Employer Telephone Number (_____)_____

Employment

☐ Employed Full Time ☐ Employed Part time
☐ Not Employed ☐ Self Employed
☐ Retired ☐ Active Military
☐ Reserves ☐ Unknown

Race

☐ America Indian ☐ Asian
☐ Black/African American ☐ Hispanic
☐ Native Hawaiian ☐ White
☐ Refuse to report ☐ Other
☐ More than one race ☐ Other Pacific Islander

Student

☐ Full Time Student ☐ Part Time Student
☐ Not a Student

Ethnicity

☐ Hispanic/Latino ☐ Refuse to Report
☐ Not Hispanic/Latino

Housing/Special Characteristics

☐ Doubling Up ☐ Homeless
☐ Migrant ☐ Seasonal
☐ Street ☐ Transitional
☐ Other ☐ Unknown
☐ Public Housing ☐ Homeless

Language

☐ English ☐ Spanish
☐ Other ☐ I need a translator

A translator will be provided if needed.

Household/Income

Total Number of people living in the house?_____

Education Level

☐ Grades K-12 ☐ Some College
☐ Associates Degree ☐ Bachelors Degree
☐ Masters Degree

Estimated Yearly income of everyone older than 18 living in the household?_____

Pharmacy Information

Do you have a vision impairment? ☐ Yes ☐ No What pharmacy do you use?_____

Do you have a hearing impairment? ☐ Yes ☐ No

Do you have trouble reading? ☐ Yes ☐ No

Do you have a religious belief against medical care?_____

Do you have an advance directive? Yes or No

Where did you receive previous immunizations?_____

Gender Identification (Please circle one below)
Male Female Transgender Male/Female-To-Male
Transgender Female/Male-To-Female Other Choose Not To Disclose

Sexual Orientation (Please circle one below)
Lesbian or Gay Straight(Not Lesbian or Gay) Bisexual
Something Else Don't Know Choose Not To Disclose

Health First Community Health Center

Consent for Treatment

In seeking medical care from Health First CHC, I do hereby voluntarily consent to such examination and treatment as is deemed necessary by the healthcare providers or Health First CHC. I understand the practice of medicine is not an exact science, and that diagnosis and treatment involve risks of injury or even death. I acknowledge that Health First providers have made no guarantees to me as a result of examination or treatment. This authorization will remain in effect until expressly revoked in writing.

_____

Patient/Guardian Signature Date

Cancellation Agreement

I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment within twenty-four (24) hours of the appointment if cancellation is needed. I understand that after three (3) missed appointments, I may be discharged from the practice.

Patient/Guardian Signature_____ Date_____

Emergency Contact

Name_____ Relationship to patient_____

Home Number (___)_____ Cell Number(____)_____

HIPAA Release

I hereby authorize Health First CHC to release to the person (s) listed below any information regarding my care, diagnosis, test results, procedures, or prognosis at any time. Example: Spouse, Parents, or Children

Name	Telephone Number	Relationship to Patient

_____

Patient/Guardian Signature Date

Notice of Privacy Practices, Patient Rights and Responsibilities

Acknowledgement of Receipt: I have received a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities for Health First CHC.

_____

Patient/Guardian Signature Date

Person Responsible for Statement

Last Name_____ Date of Birth (mm/dd/yyyy)_____

First Name_____ Sex ☐ Male ☐ Female

Physical Address_____ Social Security Number_____

Mailing Address_____ Home Number (____)_____

_____ Cell Number (____)_____

State_____ Zip Code_____ Work Number (____)_____

For and in consideration of services rendered or to be rendered to the named patient, I or we, or either of us do hereby promise to pay Health First CHC the full amount of all charges incurred. I understand that Health First CHC will file commercial insurance as a courtesy. Health First CHC will allow 30 days for the insurance to resolve the outstanding charges at which time all charges will become due and payable by the financially responsible person(s). This authorization will remain in effect until expressly revoked in writing.

I understand that copayments, co-insurance and sliding scale fees are due at time of service.

_____

Patient/Guardian Signature Date

Health First Community Health Center

Insurance Information

Primary Insurance

Primary insurance company's name_____

Address of Insurance_____

Identification Number_____

Group Number_____

Name of policy holder_____

Patient's relationship to policy holder_____

Policy holders social security number_____

Policy holders date of birth_____

Secondary Insurance

Primary insurance company's name_____

Address of Insurance_____

Identification Number_____

Group Number_____

Name of policy holder_____

Patient's relationship to policy holder_____

Policy holders social security number_____

Policy holders date of birth_____

Tertiary Insurance

Primary insurance company's name_____

Address of Insurance_____

Identification Number_____

Group Number_____

Name of policy holder_____

Patient's relationship to policy holder_____

Policy holders social security number_____

Policy holders date of birth_____

Worker's Compensation/Accident Information

Accident Date/Time_____

Claim/File Number_____

Insurance company name_____

Contact Person_____

Address_____

Assignment of Benefit

The above information is true to the best of my knowledge. I hereby assign all medical benefits and/or payments as may be due from any insurance held by me to be paid directly to Health First CHC. I also understand and agree that priviledged information to be released may include any records relating to alcohol abuse, drug abuse, AIDS/HIV, venereal disease, sexual or child abuse, mental disorders, and any information required to process my claims. This authorization will remain in effect until expressly revoked in writing.

_____

Patient/Guardian Signature Date