PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss Last name: First: Middle:

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

Community Health Services