Community Health Care, Inc.
Opening Doors to Health Care

MRN #: _____

Patient Information Form

Patient Information – Demographics

First Name: _____ **Middle Initial:** ____ **Last Name:** _____**Preferred Name** _____

Preferred Pronouns: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ xe/xem/xyrs ☐ ze/hir/hirs ☐ ey/em/eirs ☐ ve/vir/vis ☐ Other ☐ Name only ☐ Decline to answer

Date of Birth: (Month)_____ (Day)_____ (Year)_____ **Birth Sex:** ☐Male ☐Female ☐Decline to answer

Mailing Address: _____**Apt:** ____ **City:** _____ **State:** ____ **Zip Code:** _____

Primary Phone Number: _____ **Email Address:** _____

What Language do you speak at home? ☐English ☐Spanish ☐Vietnamese ☐Other_____
Marital Status: ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated ☐Significant Other
Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Retired ☐Student (☐Full Time/☐Part Time)

In Case of Emergency:

Emergency Contact Name: _____ Relationship to patient: _____

Emergency Contact Phone Number: _____

UDS

Veteran/Military Experience: ☐Yes ☐No

Race (select all that apply): ☐Black/ African American ☐White ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Guamanian or Chamorro ☐Samoan ☐Native American ☐ Alaska Native ☐Unreported/Choose not to disclose race

Ethnicity: ☐Mexican, Mexican American, Chicano/o ☐Puerto Rican ☐Cuban ☐Another Hispanic, Latino/a or Spanish origin ☐Not Hispanic, Latino/a or Spanish origin ☐Unreported/ Choose not to disclose ethnicity

Housing Status: ☐Stable Housing ☐Transitional Housing ☐Living in Shelter ☐Living with others ☐Street, Camp, Bridge ☐ Other: _____
Is the patient a Migrant/Seasonal Worker: ☐Yes ☐No

Insurance and Billing Information

Do you have insurance? ☐Yes ☐No If Yes, what type: ☐Private Insurance ☐Medicaid ☐Medicare

Primary Medical Insurance:_____ Dental Insurance:_____

If you have Private Insurance, please fill in the Insurance Policy holder information below <u>if different from the Patient.</u>

Insurance Policy holder Name: _____ DOB: _____

Mailing Address: _____Apt. #_____

City: _____ State: _____Zip Code: _____

For Minor Patients ONLY – Parent/Legal Guardian Responsible for Payments

Guarantor Name: _____ Guarantor DOB: _____

- The above information I provided is true.
- I give my permission to release of health/financial information that is needed to conduct audits and/ or process insurance claims including: HIV, mental health, STDs, genetic testing, and drug abuse.
- I agree to notify CHC Immediately should there be a change in demographics, insurance coverage, etc.

Please sign here.

Patient Signature or Parent/Legal Guardian Signature **Date**