COMMUNITY
HEALTH
ALLIANCE

PATIENT INFORMATION

Last Name:	First Name:	M.I:	Preferred Name:	DOB: / /
Social Security Number:		Home Phone:	Cell Phone:	Work Phone:
Street Address:		City:	State:	Zip:
Emergency Contact:	Relationship to Patient:	Phone Number:	Patient Email: ☐Declined	

Marital Status: ☐Child ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Student: ☐ Yes ☐ No

Race Group: ☐ White ☐ Black ☐ Asian ☐ Native American/Alaskan
☐ Hawaiian ☐ Other Pacific Islander
☐ Decline to Answer ☐Other______________________

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ Tagalog
☐ Other: _________________________________

Hearing Impaired: ☐Yes ☐No
Need Interpreter: ☐Yes ☐No

Visual Impaired: ☐ Yes ☐No
Need Accommodations: ☐ Yes ☐ No

Sex at Birth:
☐ Male ☐Female ☐ Unknown

Preferred Pronoun(s):
☐ He, Him, His
☐ She, Her, Hers
☐ They, Them, Theirs
☐ Decline to Answer

Sexual Orientation:
☐ Lesbian, Gay, Homosexual
☐ Do not know
☐ Straight or Heterosexual
☐ Choose not to disclose
☐ Bisexual
☐ Other, please specify

What is your current gender identity?
(please check all that apply)
☐ Male
☐ Transgender (male to female)
☐ Female
☐ Genderqueer (neither male nor female)
☐ Transgender (female to male)
☐ Choose not to disclose
☐ Other/Something else, Specify:

Employment Status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired

Occupation:

(Check one) ☐ Annual Household Income ☐Monthly Household Income
Household Income $____________________ Family Size_______________

Veteran? ☐Yes ☐No

Homeless: ☐Yes ☐No (If yes, please choose one option below)

☐Street ☐Doubling Up ☐Homeless Shelter ☐Transitional Housing ☐Permanent Supportive Housing* ☐Other (e.g. weekly rental)

*Housing with Supportive Services and no time restrictions

How did you hear about us? ☐Brochure/flyer ☐Family/Friend ☐TV ☐Radio ☐Newspaper/Magazine ☐Website/Online
☐Social Media ☐Health Event ☐Other:

Please see other side

GUARDIAN/PARENT RESPONSIBLE PARTY				
Last Name:	First:	Middle Initial:	☐Male ☐Female	Marital Status:
Last Name:	First:	Middle Initial:	☐Male ☐Female	Marital Status:
Address (if different):		City:	State:	Zip:
Home Phone:		Cell Phone:	Work Phone:	
Social Security:	Date of Birth:	Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian Other:		
Financially Responsible: ☐Self ☐Parent ☐Guardian ☐Power of Attorney			**Document on File:** ☐Yes ☐No	

PRIMARY INSURANCE		
Primary Insurance Company:		Insurance ID Number:
Policy Holder's Name (if different)	Relationship to Patient:	Insurance Group Number:
Insured Social Security Number:	Insured Birth Date:	Primary Phone:
Employer:		Employer Phone:
Dental Insurance:	Carrier:	Phone Number:
Dental Insurance ID Number:		Dental Insurance Group Number:

SECONDARY INSURANCE		
Secondary Insurance Company:		Insurance ID Number:
Policy Holder's Name (if different)	Relationship to Patient:	Insurance Group Number:
Insured Social Security Number:	Insured Birth Date:	Primary Phone:
Employer:		Employer Phone:
Dental Insurance:	Carrier:	Phone Number:
Dental Insurance ID Number:		Dental Insurance Group Number:

Please initial Each Item if giving Consent and sign at the bottom:

PATIENT CONSENT	
____________	I give permission to receive outpatient care at Community Health Alliance (CHA), including routine examinations, minor diagnostic and surgical procedures performed by the CHA Medical/Dental Staff
____________	I received , read and understand the Community Health Alliance (CHA) Patients' Rights and Responsibilities and my questions were answered by CHA staff (Pages 3-7)
(Choose one) ___________ ____________	I give permission for the performance of blood test to detect antibodies for HIV I refuse to give permission for the performance of a blood test to detect antibodies for HIV
OFFICE POLICIES	
_____________	I received, read and understand CHA policy regarding acute pain controlled substances, and my questions were answered by CHA staff (pages 5-6)
_____________	I received , read and understand CHA that no chronic pain management services with opiate-based medications will be prescribed, and my questions were answered by CHA staff (Pages 5-6)
_____________	I received, read and understand the CHA policies and Missed and Late Appointments, and my questions were answered by CHA staff (Pages 4-5)
CONSENT FOR BILLING	
_____________	All co-payments, deposits and sliding fees are due and payable at the time of check-in. I assign all insurance payments to be made directly to CHA. This authorization and assignment is a permanent. I reserve the right to revoke this at any time with my written notice. (Pages 6-7)
_____________	I understand that it is my responsibility to confirm with my insurance carrier the participating provider status of CHA and I will be responsible for any chargers incurred resulting from failure to do so.
_____________	I hereby authorize CHA to release information necessary to file and/or process a claim with my insurance company.
CONFIDENTIAL COMMUNICATION AUTHORIZATION	
_____________	I authorize confidential and detailed voicemail and text messages to be left at the following phone number: ______________________ Type: ☐ Cell ☐ Work ☐Home ☐Other (specify) _____________
_____________	I authorize confidential mail correspondence to be sent to my home: ☐ Yes ☐ No
_____________	I authorize CHA and its assigned clinical staff to communicate with me electronically via Patient Portal account. I understand that web based communication is a choice and I may choose to not register with My Patient Portal
TELEHEALTH CONSENT	
_____________	I authorize CHA to use the telehealth practice platform, including the right to photograph and/or record me, my image and voice for evaluating, testing, diagnosing and treating in the course of any clinical care.
ELECTRONIC HEALTH INFORMATION EXCHANGE CONSENT	
(Choose one) _____________	**I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.
_____________	**I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency
_____________	**I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

The information I have provided is true and correct to the best of my knowledge. I have read and understand the above information and agree to comply with the terms above for services rendered by CHA.

____ ____________

Signature of Patient, Parent, or Legal Guardian Date

____ ______________________________

Print Name Print Staff Name