



Date: _____

**We are a Federally Qualified Health Center and are required to collect this data.
The following information is for data collection purposes and will not affect your care.**

Demographic Information			
Legal Name: _____	Date of Birth: _____		
Previous Name: _____	Social Security Number: _____		
Preferred Name: _____	Phone Numbers	Select Best Number to Use	OK to Leave Voicemail?
Mailing Address: _____	Home (____) ____-____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
City, State, Zip: _____	Cell (____) ____-____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address: _____	Work (____) ____-____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to be registered for our Patient Portal? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Birth Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Sexual Orientation <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose		
Income Information - Assists us in reviewing & assessing the Poverty Levels of our entire patient population			
What is the annual household income? \$ _____ <input type="checkbox"/> Choose not to disclose			
How many people (including yourself) does this income support? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Other _____			
It is the policy of the CHCNC to offer a sliding fee schedule for all patients who are at or below 200% of the poverty level.			
Do you wish to speak with someone regarding our sliding fee schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Information			
Primary Medical Insurance <input type="checkbox"/> I do not have Medical Insurance Insurance Company Name: _____ Medical Policy #: _____ Policyholder Name: _____ Policyholder Date of Birth: _____ Policyholder Social Security Number: _____	Primary Dental Insurance (Dental Patients Only) <input type="checkbox"/> I do not have Dental Insurance Insurance Company Name: _____ Dental Policy #: _____ Policyholder Name: _____ Policyholder Date of Birth: _____ Policyholder Social Security Number: _____		
Responsible Party Information - <i>Person who is responsible for Payment of Patient's Account</i>	Emergency Contact		
<input type="checkbox"/> Same as Patient Name: _____ DOB: _____ Social Security Number: _____ Address: _____ City, State, Zip: _____ Phone Number: _____ Relationship to Patient: (*Proof of Legal Status is Required) ___ Self ___ Parent ___ Guardian ___ Custodial Parent* ___ Foster Parent* Foster Parent Agency _____	Name: _____ Phone Number: _____ Relation to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Family Member <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend		

Date: _____

<p>Marital Status</p> <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed	<p>Language</p> <input type="checkbox"/> English <input type="checkbox"/> Español <input type="checkbox"/> Français <input type="checkbox"/> Other _____ <input type="checkbox"/> Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Racial Group(s)</p> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other _____ <input type="checkbox"/> Decline to Specify
<p>Other Characteristic(s)</p> <input type="checkbox"/> Amish <input type="checkbox"/> Homeless <input type="checkbox"/> Individual with a Developmental Disability <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> Veteran <input type="checkbox"/> None <input type="checkbox"/> Choose not to report	<p>Ethnicity</p> <input type="checkbox"/> Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other _____ <input type="checkbox"/> Decline to Specify	

Employment/Education Information

<input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time Employer Name: _____ Are you covered by your Employer's Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Other Are you covered by your School's Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Student Full-Time <input type="checkbox"/> Student Part-Time School/College Name: _____ Are you covered by your School's Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Pharmacy Information

Preferred Pharmacy: _____ City/State: _____	Is it okay to text you appointment confirmations and notifications of prescriptions sent to your Pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Other Information

How did you hear about us? _____	Primary Care Provider: _____
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Consent to Discuss Protected Health Information - Protected Health Information (PHI) means individually identifiable information relating to past, present, or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual. Healthcare Treatment consists of services provided by each discipline within CHCNC: Primary, Mental Health, Dental, Pediatrics, Physical Therapy, Dermatology, Women's Health Services and Foot Care. This consent is limited, and does not include permission to discuss Alcohol/Drug Treatment or confidential HIV/AIDS –related information, which needs a special signed release.

Permission to Accompany for MINOR Patients ONLY (Under Age of 18) The following individual(s) have my permission to accompany the above named minor child to a healthcare appointment at Community Health Center of the North Country. I understand that this person will be privy to PHI. I understand that if an invasive procedure or immunizations are needed, I will need to bring the child in or be available for telephone consent.

I give permission to CHCNC to discuss my PHI (or the PHI of the above named patient I'm authorized to consent for) with the following individuals:

Name:	Relationship:	Phone:	<u>Consent to Discuss PHI</u>	<u>Permission to Accompany Minor</u>
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

I understand I have the right to revoke these permissions, in writing, at any time, except in regards to actions the Health Center has already taken due to this consent.

Patient/Legal Guardian Print Name: _____ **Signature:** _____

CHCNC OFFICE USE ONLY - I have reviewed with the patient and explained the importance of collecting this information.

Staff Signature: _____ Date: _____