Todays Date:_____

CHPC Christopher Rural Health Planning Corporation

PATIENT INFORMATION

Last Name: First Name: Middle:		Date of Birth:	Social Security #:
Street Address:	City:	State:	Zip Code:
Mailing Address: ❑Same as above	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email (Used for Patient Portal):	
Preferred Language: ❑Check here if interpreter needed	Primary Care Provider:	Contact Preference: ❑Voice ❑Text	Primary Pharmacy Name:

Please complete this section if applicable:

Patient Marital Status:	Patient Employer Name:	Patient Employment Status:	Advance Directive: ❑Yes ❑No

As a Federally Qualified Health Center, we are required to collect certain information, please complete the following:

Veteran: ❑Yes ❑No	**Gender Identity:** ❑Male ❑Female ❑Transgender Male ❑Transgender Female ❑Other ❑Choose not to disclose Sex assigned at birth:_____	**Sexual Orientation**:❑Straight ❑Lesbian/Gay ❑Bisexual ❑Something else ❑Don't Know ❑Choose not to disclose
Race (Check all that apply): ❑White ❑Black ❑Native Hawaiian ❑Other Pacific Islander ❑Indian/Alaskan Native ❑Asian ❑Filipino ❑Japanese ❑ Korean ❑Guamanian or Chamorro ❑Chinese ❑Samoan ❑Other:_____ ❑Refuse	**Ethnicity:** ❑Hispanic Latino ❑Non-Hispanic Latino ❑Puerto Rican ❑Cuban ❑Other:_____ ❑ Mexican/Mexican American ❑Refuse	**Household Information:** ❑Homeless ❑Public Housing No. in household:_____ Annual Income:_____ ❑Check here if interested in learning about our discount programs

RESPONSIBLE PARTY INFORMATION (PERSON TO RECEIVE BILLING STATEMENT)

Last Name: ❑Same as patient First Name: Middle:		Date of Birth:	Social Security #:
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	Driver's License #:	Relationship to patient:	

INSURANCE INFORMATION (PLEASE GIVE PHOTO ID AND INSURANCE CARD(S) TO THE RECEPTIONIST)

Name of Insurance:	Subscriber No:	Group No:
Insured Name: ❑Same as patient Last Name: First Name: Middle:		
Patient relationship to insured:	Date of Birth:	Social Security #:

EMERGENCY CONTACT INFORMATION

Last Name: First Name: Middle:		Telephone Number:	
Address:	City:	State:	Zip Code:
Relationship to patient:			

Christopher Rural Health tries to meet your special needs. Please help us by circling or noting items you would like assistance with:

❑Sign Language/Interpreter ❑Translator ❑ Financial Assistance ❑Other:_____