

Today's Date: _____

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

Please complete this section if applicable:

Patient Marital Status:	Patient Employer Name:	Patient Employment Status:	Advance Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No
-------------------------	------------------------	----------------------------	--

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

Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Chinese <input type="checkbox"/> Samoan <input type="checkbox"/> Other: _____ <input type="checkbox"/> Refuse	Ethnicity: <input type="checkbox"/> Hispanic Latino <input type="checkbox"/> Non-Hispanic Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____ <input type="checkbox"/> Mexican/Mexican American <input type="checkbox"/> Refuse	Household Information: <input type="checkbox"/> Homeless No. in household: _____ <input type="checkbox"/> Public Housing Annual Income: _____ <input type="checkbox"/> Check here if interested in learning about our discount programs

RESPONSIBLE PARTY INFORMATION (PERSON TO RECEIVE BILLING STATEMENT)

Last Name: <input type="checkbox"/> 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: <input type="checkbox"/> 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: _____