|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TODAY’S DATE:** | | | | | | | | | **PRIMARY CARE PROVIDER:** | | | | | | | | | | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient’s Last Name:** | | | | | **First Name:** | | | | | | | | | | **Middle Name:** | | | | **Suffix:** | | | **Social Security No.:** | | | | |
| **Is this your legal name?**  Yes  No | | | | **If not, what is your legal name?** | | | | | | | | | | | | **Former Name(s):** | | | | | | | | | | |
| **Birth Date (MM/DD/YYYY):**        /       / | | | | | | **Mailing Address:** | | | | | | | | **City:** | | | | **State:** | | | | | | | | **Postal Code:** |
| **Physical Address:** | | | | | | | | | | | | | **City:** | | | **State:** | | | | | **Postal Code:** | | | | | |
| **Marital Status:** | Single  Married  Divorced  Separated  Widow  Minor | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Home Phone:**  (     ) | | | **Cell Phone:**  (     ) | | | | | | | | **Work Phone:**  (     ) | | | | | **Email Address:** | | | | | | | | | | |
| **Preferred method of contact:**  Home Phone  Cell Phone  Work Phone  Email  **Is it OK to leave a detailed message at this number?**  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADDITIONAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Occupation:** | | | | | | | | | **Employer:** | | | | | | | | | | | | **Employer Phone No.:**  (     ) | | | | | |
| **Are you Homeless?**  Yes  No  **Are you a Seasonal Worker?**  Yes  No  **Preferred Language:**  English  American Sign Language  Other:  **Are interpreter services needed?**  Yes  No | | | | | | | | | | | **Race: (check all that apply)**  White/Caucasian  Asian  Alaska Native  American Indian  Black/African American  Native Hawaiian  Other Pacific Islander  Other:  Decline to Answer | | | | | | | | | **Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino  Refuse to provide  **Are you a Veteran?**  Yes  No  **If yes, will you be using:**  VA Choice  Yes  No  Tricare  Yes  No | | | | | | |
| **What sex were you assigned at birth on your original birth certificate?**  Male  Female  **Which pronoun do you prefer?**  he/him  she/her  they/them  Name only  Decline to Answer | | | | | | | | **What is your current gender identity?** (Check all that apply)  Male  Female  Female-to-Male /Transgender Male /Trans Man  Male-to-Female /Transgender Female /Trans Woman  Genderqueer, neither exclusively male nor female  Other, please specify:  Decline to Answer | | | | | | | | | | | | | | | **Do you think of yourself as:**  Straight or heterosexual  Lesbian, gay, or homosexual  Bisexual  Something else  Don’t know  Decline to Answer | | | |
| **PATIENT’S NAME:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Local Friend or Relative:** | | | | | | | | | | **Relationship to Patient:** | | | | | | | **Contact Cell Phone:**  (     ) | | | | | | | **Contact Work Phone:**  (     ) | | |
| **HOUSEHOLD INCOME** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please check the box below indicating your **estimated** household annual income according to the number of people living in your home. Seward Community Health Center is required to report this information to the Federal Government, and it helps us to better understand the needs of the community we serve. No identifying information shall be disclosed in any of our required reports. Your anonymity is protected. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **# of People in Household** | |  | | | | |  | | | | | | |  | | |  | | | | | | | |  | |
| **1 person 🡪** | | $0 - $15,600 | | | | | $15,601 - $23,400 | | | | | | | $22,401 - $27,300 | | | $27,301 - $31,200 | | | | | | | | More than $31,200 | |
| **2 people 🡪** | | $0 - $21,130 | | | | | $21,131 - $31,695 | | | | | | | $31,696 - $36,978 | | | $36,979 - $42,260 | | | | | | | | More than $42,260 | |
| **3 people 🡪** | | $0 - $26,660 | | | | | $26,661 - $39,990 | | | | | | | $39,991 - $46,655 | | | $46,656 - $53,320 | | | | | | | | More than $53,320 | |
| **4 people 🡪** | | $0 - $32,190 | | | | | $32,191 - $48,285 | | | | | | | $48,286 - $56,333 | | | $56,334 - $64,380 | | | | | | | | More than $64,380 | |
| **5 people 🡪** | | $0 - $37,720 | | | | | $37,721 - $56,580 | | | | | | | $56,581 - $66,010 | | | $66,011 - $75,440 | | | | | | | | More than $75,440 | |
| **6 people 🡪** | | $0 - $43,250 | | | | | $43,251 - $64,875 | | | | | | | $64,876 - $75,688 | | | $75,689 - $86,500 | | | | | | | | More than $86,500 | |
| **7 people 🡪** | | $0 - $48,780 | | | | | $48,781 - $73,170 | | | | | | | $73,171 - $85,365 | | | $85,366 - $97,560 | | | | | | | | More than $97,560 | |
| **8 people 🡪** | | $0 - $54,310 | | | | | $54,311 - $81,465 | | | | | | | $81,466 - $95,043 | | | $95,044 - $108,620 | | | | | | | | More than $108,620 | |
|  | |  | | | | |  | | | | | | |  | | |  | | | | | | | | Decline to Answer | |
| **PATIENT HEALTHCARE PROVIDER(S)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Do you have other healthcare provider(s)?**  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Provider’s Name(s):** | | | | | | | | | | | | **Provider’s Specialty (e.g., cardiology, oncology, internal medicine):** | | | | | | | | | | | | | | |
| **Do you have Advance Care Directives?**  Yes  No | | | | | | | | | | | | **Do you need transportation assistance?**  Yes  No | | | | | | | | | | | | | | |
| **How did you hear about Seward Community Health Center?** (Check all that apply)  Providence ER  Employer  Other Provider   Internet Search  Radio  Newspaper  Friends/Family  Social Media  Website  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT’S NAME:** | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | |
| *Please give your insurance card to the front desk staff along with photo I.D.* | | | | | | | | | | | | | | |
| **Person responsible for bill** (If different from Patient): | | | | **Birth Date:**        /       / | | | | **Mailing Address:** | | | | | | **Work Phone:**  (     ) |
| **Is this person a patient here?**   Yes  No | | | | | | | **Is this patient covered by insurance?**  Yes  No | | | | | | | |
| **Occupation:** | | | **Employer:** | | | | | | **Employer Address:** | | | | | **Employer Phone:**  (     ) |
| **Primary insurance carrier:** | | | | | | | **Subscriber’s name:** | | | | | | | |
| **Subscriber’s S.S. No.:** | | **Birth Date:**        /       / | | | **Group no.:** | | | | | **Policy no.:** | | | | **Co-Payment:**  $ |
| **Patient’s relationship to subscriber:**   Self  Spouse  Child  Other: | | | | | | | | | | | | | | |
| **Secondary insurance carrier:** | | | | | | | **Subscriber’s name:** | | | | | | | |
| **Subscriber’s S.S. No.:** | | **Birth Date:**        /       / | | | **Group no.:** | | | | | **Policy no.:** | | | | **Co-Payment:**  $ |
| **Patient’s relationship to subscriber:**   Self  Spouse  Child  Other: | | | | | | | | | | | | | | |
| **RELEASE OF PROTECTED HEALTH INFORMATION** | | | | | | | | | | | | | | |
| I authorize, by signing below, SCHC to release by Protected Health Information (PHI), which includes appointment time/information, billing questions/concerns, and individually identifiable health information to: | | | | | | | | | | | | | | |
| Name: |  | | | DOB: | |  | | | | | Relationship to Patient: | |  | |
| Name: |  | | | DOB: | |  | | | | | Relationship to Patient: | |  | |
| **ACKNOWLEDGEMENT & AUTHORIZATION FOR PAYMENT** | | | | | | | | | | | | | | |
| ◆ The above information is true to the best of my knowledge. I assign directly to Seward Community Health Center all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all changes whether or not paid by my insurance**. I hereby authorize the clinic to release all information necessary to secure the payment of benefits. I understand that my account should be paid within 30 days.  ◆ I also understand that should my account be referred to an attorney or collection agency, I shall pay the attorney’s fee and/or collection agency expenses. All delinquent patient accounts may be charged interest at the legal rate. I authorize the use of this signature for all insurance submissions.  ◆ I have read the Patients’ Rights and Responsibilities and agree to hold myself and the staff of SCHC to those standards. | | | | | | | | | | | | | | |
| **Patient/Guardian Signature:** | | | | | | | | | | | | **Date:** | | |