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| **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 [ ]  NoTricare [ ]  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:       |

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| **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:**       |