

ADULT PATIENT INFORMATION

Patient Name _____ Birth date _____ Race: _____ Sex: M _____ F _____
(for statistical purposes only)

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Social Security # _____ Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Employer Name _____ Address _____ Phone _____

SPOUSE / PARENT / GUARDIAN INFORMATION (please circle one)

Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Social Security # _____

Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Phone _____

PATIENT INSURANCE COVERAGE

Primary Insurance _____ Group/ID # _____

Secondary Insurance _____ Group/ID # _____

DO YOU HAVE MEDICAID OR MEDICARE COVERAGE? Yes _____ No _____ (If yes, please give # below)

Medicaid # _____ Medicare # _____

ARE YOU SELF-PAY? Yes _____ No _____ (A sliding fee scale is required for all self-pay patients)

I hereby authorize the release of any medical/dental information necessary for the processing of insurance. I also authorize insurance benefits to be paid directly to Community Health Services. I understand that if my insurance does not pay, I am responsible for payment of services provided.

Signature _____ Date _____

