CHS **Community Health Services**
Your Partners for Better Health

Please check which services you are registering for: ☐ Medical ☐ Dental ☐ Both

For patients 18 and older please complete sections 1 & 3 along with remainder of the form.
For patients 17 and younger please complete sections 2 & 3 along with remainder of the form.

SECTION 1: ADULT PATIENT INFORMATION

Patient Name _____ Birth date_____ Sex: ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Primary Phone_____ Cell Phone _____

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

E-Mail Address _____ **Are you a veteran? ☐ Yes ☐ No**

Race: _____ Hispanic/Latino : ☐ YES ☐ NO Primary Language Spoken: _____
(for statistical purposes only)

Number of Members in Household: _____ Annual Household Income: $ _____

Select one: ☐ **SPOUSE** ☐ **PARTNER** ☐ **POWER OF ATTORNEY**

Name_____ Birth date_____

Address_____ City_____ State_____ Zip _____

Phone_____ Social Security #_____

SECTION 2: CHILD PATIENT INFORMATION

Patient Name _____ Birth date_____ Sex: ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Primary Phone: _____ Social Security #: _____

Race: _____ Hispanic/Latino : ☐ YES ☐ NO Primary Language Spoken: _____
(for statistical purposes only)

Number of Members in Household: _____ Annual Household Income: $ _____

Select one: ☐ PARENT ☐ GUARDIAN

Mother's/Guardian's Name: _____ Birth Date: _____

Mother's/Guardian's Address: _____ City: _____ State: _____ Zip: _____

Phone_____ Social Security #_____

Mother's E-Mail Address: _____

SECTION 2 Continued:

Father's/Guardian's Name: _____ Birth Date: _____

Father's/Guardian's Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____

Father's E-Mail Address: _____

SECTION 3: EMERGENCY CONTACT

Emergency Contact _____ Phone_____

PATIENT INSURANCE COVERAGE - MEDICAL

Primary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

PATIENT INSURANCE COVERAGE - DENTAL

Primary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

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

Medicaid MMIS # _____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 third party payers. 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_____

Relationship to Patient (please select one): ☐ Self ☐ Power of Attorney ☐ Parent/Guardian

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