CHS Community Health Services
Your Partners for Better Health

Please indicate all services for which you are applying: ☐ **Medical** ☐ **Dental**

SECTION 1: ADULT PATIENT INFORMATION *(18 and above)*

PATIENT NAME _____ DATE OF BIRTH ___/___/___ SEX: ☐ M ☐ F

ADDRESS – CITY, STATE & ZIP _____

PRIMARY PHONE NUMBER _____ CELL NUMBER _____ SOCIAL SECURITY NUMBER ___-___-___

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow ARE YOU A VETERAN? ☐ Yes ☐ No

PRIMARY LANGUAGE SPOKEN _____ RACE _____ HISPANIC / LATINO: ☐ Yes ☐ No

EMAIL ADDRESS _____

SPOUSE / PARTNER / POWER OF ATTORNEY INFORMATION ☐ Spouse ☐ Partner ☐ Power of Attorney

NAME _____ DATE OF BIRTH ___/___/___

ADDRESS – CITY, STATE & ZIP _____

PRIMARY PHONE NUMBER _____ SOCIAL SECURITY NUMBER ___-___-___

SECTION 2: CHILD PATIENT INFORMATION *(17 and below)*

PATIENT NAME _____ DATE OF BIRTH ___/___/___ SEX: ☐ M ☐ F

ADDRESS – CITY, STATE & ZIP _____

PRIMARY PHONE NUMBER _____ SOCIAL SECURITY NUMBER ___-___-___

PRIMARY LANGUAGE SPOKEN _____ RACE _____ HISPANIC / LATINO: ☐ Yes ☐ No

PARENT / GUARDIAN INFORMATION ☐ Parent ☐ Guardian

MOTHER / GUARDIAN NAME _____ DATE OF BIRTH ___/___/___

ADDRESS – CITY, STATE & ZIP _____

PRIMARY PHONE NUMBER _____ SOCIAL SECURITY NUMBER ___-___-___ EMAIL ADDRESS _____

FATHER / GUARDIAN NAME _____ DATE OF BIRTH ___/___/___

ADDRESS – CITY, STATE & ZIP _____

PRIMARY PHONE NUMBER _____ SOCIAL SECURITY NUMBER ___-___-___ EMAIL ADDRESS _____

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SECTION 3: EMERGENCY CONTACT *(all patients)*

EMERGENCY CONTACT _____ PRIMARY PHONE NUMBER _____

SECTION 4: INSURANCE INFORMATION

MEDICARE / MEDICAID / MANAGED CARE

MEDICAID MMS # _____ MEDICARE # _____

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

PATIENT INSURANCE COVERAGE – MEDICAL

PRIMARY INSURANCE _____ ID # _____ GROUP# _____

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER BIRTH DATE ___/___/___ SUBSCRIBER SOCIAL SECURITY # ___-___-___

SECONDARY INSURANCE _____ ID # _____ GROUP# _____

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER BIRTH DATE ___/___/___ SUBSCRIBER SOCIAL SECURITY # ___-___-___

PATIENT INSURANCE COVERAGE – DENTAL

PRIMARY INSURANCE _____ ID # _____ GROUP# _____

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER BIRTH DATE ___/___/___ SUBSCRIBER SOCIAL SECURITY # ___-___-___

SECONDARY INSURANCE _____ ID # _____ GROUP# _____

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER BIRTH DATE ___/___/___ SUBSCRIBER SOCIAL SECURITY # ___-___-___

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 if my insurance does not pay, I am responsible for payment of services provided.

SIGNATURE _____ DATE ___/___/___