



Community Health Centers

<b>PATIENT INFORMATION</b>	<b>RESPONSIBLE PARTY INFORMATION</b> <i>(Parent, guardian, spouse, etc.)</i>
Name First Middle Last	Name First Middle Last
Date of Birth _____	Relationship _____
Sex F [ ] M [ ]	Date of Birth _____ Sex F [ ] M [ ]
Social Security #	Social Security #
Address	Address
City State Zip	City State Zip
Home Phone Message	Home Phone Message
Employer Name	Employer Name
Address	Address
City State Zip	City State Zip
Work Phone	Work Phone
<b><i>The information below should be completed by the responsible party</i></b>	
Marital Status Married [ ] Single [ ] Separated [ ] Divorced [ ] Widowed [ ] Other [ ]	
Income \$ _____ Week [ ] Month [ ] Year [ ] Family Size _____	
Employed in Agriculture Yes [ ] No [ ] If Yes, Seasonal [ ] Or Migrant [ ]	
Emergency Contact _____ Phone # _____	
Insurance Coverage Medi-Cal [ ] Medi-Care [ ] Private Ins. [ ] None [ ] Other _____	
<b>Please provide receptionist with a copy of your Insurance ID card</b>	

I certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process this claim for treatment, payment, or operations. I authorize payment of medical benefits to CHC, provider or suppliers for services. I, the undersigned hereby authorize the provider and whomever else he may designate as his assistant (s), to administer those treatments and procedures which in his opinion are deemed necessary.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medical Record # \_\_\_\_\_