Patient Information

CHRIST COMMUNITY DENTAL

Patient Name	Last	First	Middle Initial	Date of Birth

Home Address	House #	Street	Apt #	City	State	Zip

Mailing Address	House #	Street	Apt #	City	State	Zip

☐ Check this box and leave mailing address blank if it is the same as your home address

Email Address	May we contact you via email? (circle one) Yes | No
Home Phone ( ) -	May we leave a voicemail? (circle one) Yes | No
Cell Phone ( ) -	May we leave a voicemail? (circle one) Yes | No May we send a text message? (circle one) Yes | No
Work Phone ( ) -	May we leave a voicemail? (circle one) Yes | No
Gender: Female | Male	**Social Security #:** - -
Pharmacy Name:	

Insurance Information (Please copy this information from your insurance card)

☐ Check this box if the patient does not have any health insurance.

Primary Insurance

Carrier (Company)	Group ID	Office Visit Copay
		$

Subscriber Name	Subscriber Date of Birth

Policy Holder ID (for the patient)	**Subscriber's Relation to Patient** (circle one)
	Self | Spouse | Partner | Child | Other ____________________

Secondary Insurance

Carrier (Company)	Group ID	Office Visit Copay
		$

Subscriber Name	Subscriber Date of Birth

Policy Holder ID (for the patient)	**Subscriber's Relation to Patient** (circle one)
	Self | Spouse | Partner | Child | Other ____________________

Patient Information (page 2)

Responsible Party

☐ I am the patient. (You may skip this section; go to additional Information)

If you are the parent/legal guardian or are otherwise responsible for authorizing care and paying bills for the patient named above, please provide your name and contact information below.

The patient is my (circle one): Spouse | Partner | Child | Other ________________

Name	Last	First	Date of Birth	SSN

Mailing Address	House #	Street	Apt #	City	State	Zip

Email Address

Additional PATIENT Information

Please circle one option for each question below. We are required to ask these questions, but you may skip any you are not comfortable answering.

Marital Status? Single | Married | Partner | Widowed | Divorced | Legally Separated

Employment Status? Full-time | Part-time | Not Employed | Self-Employed | Retired | Active Military | Student

Race? American Indian/Alaska, Native | Black or African American | White
Asian Indian | Chinese | Filipino | Japanese | Korean | Vietnamese | Other Asian
Native Hawaiian | Guamanian or Chamorro | Samoan | Other Pacific Islander

Ethnicity? Mexican, Mexican American, Chicano/a | Puerto Rican | Cuban | Other Hispanic, Latino/a | Not Hispanic, Latino/a

Are you a veteran? Yes | No Primary Language? English | Spanish | Other ________________ Need interpretation services? Yes | No

Are you a public housing resident? Yes | No If yes, which housing development? ________________________________

Are you homeless? Yes | No If yes, what is your status? Street | Doubling Up | Transitional Housing | Shelter ______________________

Is your main employment in agriculture on a seasonal basis (Seasonal Agricultural Worker)? Yes | No

Do you move (migrate) through the year for agricultural work (Migratory Agricultural Worker)? Yes | No

Sexual Orientation? Straight/Heterosexual | Lesbian or Gay | Bisexual | Other | Don't Know | Choose not to disclose

Gender Identity? Male | Female | Transgender/Female-to-Male | Transgender/Male-to-Female | Other | Choose not to disclose

Acknowledgements

1) I voluntarily consent to receiving services at Christ Community Health Services Augusta (CCHSA). I give permission to all CCHSA Staff to use diagnostic and procedures they deem necessary for proper medical, dental, behavioral and spiritual care.
2) I assign the payment of claims on my behalf to CCHSA. I understand some of the services I receive may not be covered by my third-party payor (Medicare, Medicaid, other insurance), and I am responsible for paying these amounts.
3) I understand payment in full is expected before I receive services at CCHSA. This includes payment of all service fees, copays, and/or coinsurance amounts as discounted based on my fee discount eligibility.
4) I understand CCHSA will not write prescriptions for narcotics at a patient's first appointment. I further understand CCHSA Providers do not guarantee that they will continue a narcotic prescription.
5) I understand CCHSA may discharge me as a patient for cause, or if I do not see a Provider at CCHSA in a 3-year period.
6) I understand Christ Community is an integrated care system, meaning that all providers work together to coordinate my care. I understand all my visit notes are part of my medical record. This means that other providers at Christ Community who care for me may have access to this information.
7) Some services at Christ Community Health may include the use of telemedicine equipment and interaction with providers who are not physically onsite. These services are conducted via secure lines and are not videotaped, routed through the internet, or saved in any means.

I affirm all information provided in this Patient Information form is true and accurate to the best of my knowledge.

______________________________	______________________________	________________
SIGNATURE of Patient or Patient's Parent/Guardian	PRINTED NAME of Patient or Patient's Parent/Guardian	DATE