COMMUNITY HEALTH NETWORK

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Last Name	First Name		Preferred Name: (If Applicable)	
Social Security Number	Date of Birth	Address	City	State
Zip Code	County	Patient by Gender Identity	Marital Status	Household Size
		☐ Male ☐ Female ☐ Transgender Male [F-to-M] ☐ Transgender Female [M-to-F] ☐ Other ☐ Choose not to disclose	☐ Single ☐ Married ☐ Divorced ☐ Common Law ☐ Other	
Mobile Phone Number	Home Phone Number			

Email Address:

Preferred Method of Contact (if needed circle more than one) :

Cell Phone Text (SMS) Email US Mail Patient Portal

Employment status	Household Income	Ethnicity:	Race	Patient Characteristics
☐ Full-time Employed ☐ Part-time Employed ☐ Unemployed ☐ Public Assistance ☐ Retired ☐ Student Occupation: ----------	☐ Monthly Amount $----------	☐ Hispanic ☐ Non-Hispanic Preferred Language ☐ English ☐ Spanish ☐ Other ----------	☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Black/ African American ☐ White ☐ American Indian ☐ More than one Race ☐ Refuse to report	☐ Migrant Worker ☐ Seasonal ☐ Homeless Shelter ☐ Transitional ☐ Doubling up ☐ Street ☐ Public Housing ☐ Veteran ☐ N/A

Patients Choices- Please Read Carefully and select "Yes" or "No" to the following Questionnaire

We would like your permission to send you SMS text messages and/or Email for Appointment Confirmation. Do you allow SMS messaging? (please circle one) **Yes** or **No** If Yes, please provide Cell Phone Number _____

Do you Allow Patient Portal? *(Please Circle One)* **Yes** or **No**
Patient Portal will allow you to view some medical records (lab results), request information or appointment online.

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Please Continue on the Next Page

Patient Registration Form

Emergency contact:	Relationship to the patient:	Phone Number	Ok to leave a message?
			☐ **Yes** ☐ **No**

Assignment of Benefits & Authorization to Release Information	**Patient Initial**
Assignment of Benefits: I hereby authorize and Direct my insurance carrier(s) plans to issue payment directly to Community Health Network for medical, dental, and behavioral health services rendered to myself and/ or my dependents. Regardless of my insurance benefits, I understand that I am responsible for any amount not covered by my insurance benefits.	
Authorization to Release Information: I hereby authorize Community Health Network to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment. This order will remain in effect until revoked by me in writing.	

If patient is a minor:

- ☐ I acknowledge that I _____ am the parent or legal guardian of the patient name above and can make decisions concerning health care services.
- ☐ I _____ acknowledge that I have obtained permission from parent or legal guardian to bring patient named above to receive healthcare services, and I am providing the documented permission to CHN.

I solemnly swear (or affirm) that the information included on this form is true and to the best of my knowledge.

Signature of Patient or Guardian	**Date**
Printed Name	**If Not Patient, List Relationship**
Staff Signature	**Date**