Community Health Center of the Black Hills, Inc

Account Number: _____

CLIENT/PATIENT INFORMATION

Name: _____ Social Security Number: _____
Last *First* *Middle*

Street Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Phone Number: (_____) _____ Female _____ Male _____ Other names used (alias): _____

Do we need to contact you at a different mailing address, phone number or through an alternate method for confidential issues? ___ Yes___ No

Mailing Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

If the client is a child are they in Foster Care? _____ Yes ____No
Is the client a Family Planning client? ____Yes ____No If yes, who may CHCBH release information to: _____

EMERGENCY/ALTERNATIVE CONTACT

***May CHCBH talk to for: emergency/ appointment information/ test results/ medication information/ billing information** (Please circle all that apply)
Name: _____

Home Phone: _____ Alternate Phone: _____

Relationship to Client: _____ Client's Legal Guardian? ____Yes ____NO

EMPLOYER INFORMATION

Employment Status: Employed Full Time/Employed Part Time/Self Employed/Retired/Military/Student Full Time /Student Part Time / Unemployed

Employer Company Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Occupation: _____

GUARANTOR (Person responsible for payment on account.) (Please make sure to provide Insurance Information in the next section)

Name: _____ Phone Number: *(_____)* _____
Last *First* *Middle*
Billing Address: _____ Date of Birth _____

City: _____ State: _____ Zip Code: _____ Relationship to Client: _____

Guarantor's Social Security Number: _____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Insurance mailing Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

POLICY HOLDER INFORMATION (Must be completed to file.)

Name of Policy Holder: _____ *Relationship to Client:* _____
Last *First* *Middle*
Policy Holder Address: _____ *Phone:*

Policy Holder SSN: _____ *Policy Holder Date of Birth:* _____ *Male* *Female (Circle one)*

Insurance ID: _____ *Group#:*_____

Effective Date: _____

Do you have additional insurance? ____Yes ____No