Date: _____ **Date of Birth**: _____ **Social Security #**:_____
Patient Full Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact numbers: Home_____ Cell Phone: _____ Relative: _____
Best time to reach you: _____ day _____ Night **Email address**: _____
Gender: Male_____ Female_____ **Age**: _____
◯ Married ◯ Widowed ◯ Single ◯ Separated ◯ Divorced ◯ Life Partner
Student Status: Fulltime ____ Part-time _____ Not a student ____ **Veteran Status**: Yes____ No____
Smoker: Yes____ No____
Emergency Contact Name: _____ Contact number: _____

******************We are required to obtain the following requested information*********************
Homeless status: Not homeless____ Doubling up____ Shelter___ Street ____ Transitional___
Migrant worker: Migrant _____ Not a farm worker _____ Seasonal _____
Language Barrier: Yes ____ No ___ **What is your primary Language Spoken**:_____
Race: Native American Indian ____ Native Hawaiian ____ White ____ Asian ____ Black/African American ____ Other Pacific Islander ____ Hispanic ___
Ethnicity: Hispanic/Latino ____ Not Hispanic ____
Primary Care Provider: _____ Primary Dentist: _____
Primary Insurance Coverage: _____
Subscribers Name: _____ Relationship to Patient: _____
Additional Insurance Coverage: _____

Number of family members in household: _____

How did you hear about CHDC? _____

*******State your household income in one of the following categories listed below********

Household income: Weekly _____ Biweekly_____ Monthly _____ Yearly_____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our Patient Financial Department. Although we will compile the necessary forms to file to your insurance company it is the responsibility of the patient to dispute any services not covered by the insurance company.

I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

_____ _____

Patient Signature **Date** **Signature of guardian if patient is under 18 years** **Date**