

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC.

PATIENT PROFILE

PATIENT INFORMATION

Name _____
Address _____
City, State, Zip _____
I am staying with : Parents /Relative/ Friend /Facility (circle one)
Name of Facility/Relative/Friend: _____
Name Phone # _____
Cell Phone # _____
Email Address _____

Patient ID# _____
Date of Birth _____
Social Security # _____
Sex M F
Marital Status Married Single Divorced Other

Employed Yes No
Employer Name _____

Did your injury occur as a result of a work related or automobile related injury/accident? YES NO
Date of Injury: _____ Referring Physician _____ Phone # _____

Medical Insurance Information

Primary Insurance Company: _____ Secondary Insurance Company: _____
Policy Holder's Name : _____ Policy Holder's Name : _____
Policy Holder's Social Security # _____ Policy Holder's Social Security # _____
Policy Holder's Date of Birth _____ Policy Holder's Date of Birth _____
Policy Identification Number _____ Policy Identification Number _____
Group Number: _____ Copay: _____ Group Number: _____ Copay: _____
Claims Address: _____ Claims Address: _____
City, State, Zip : _____ City, State, Zip: _____
Relationship to Patient: _____ Relationship to Patient: _____
Employer: _____ Employer: _____

DEMOGRAPHICS

Non-English Primary Language Yes No Deaf/ Sign Language Yes No
Interpreter Required Yes No US Citizen Yes No
Participate in Homeless Program Yes No Tobacco User Current Former
Race: White African American Somalia Hispanic Other _____
Is the Patient a Vet? Yes No Are you of Hispanic or Latino Descent? Yes No
Source that Referred you to us _____ If Patient, Name _____

If you wish to be placed on our sliding fee scale, you will need to provide proof of household income based upon the rules set forth by the federal government within thirty(30) days of today's date and every six months thereafter or if there is a change in your household income and/or insurance status.

Gross Household Income _____ Weekly Bi-Weekly Monthly Yearly
Number Living in Home (Including Patient) _____

Release of Information: I authorize this facility to disclose copies of all or any part of my medical records obtained in the course of my diagnosis and treatment to any insurance carrier, workers compensation, welfare agency, pharmaceutical manufacturer, or any other entity which may be providing financial assistance for my hospital, medical and/or nursing care. I understand that this disclosure may include information concerning Human Immunodeficiency Virus (HIV) testing, Acquired Immune Deficiency Syndrome (AIDS) or AIDS related condition(s), psychiatric condition(s), and/or alcoholism or drug abuse. I also authorize the release medical information for utilization and quality assurance review to my insurer or their subcontractors and as required by any city, state, or federal laws.

Assignment of Benefits: I authorize payment of any insurance benefits directly to CNHC. I understand that I am financially responsible for any charges not covered by this authorization, and all bills not paid in a timely manner by my insurance carrier.

I have read and understand the Notice of Privacy Practice Brochure

Initial

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Patient ID# _____

Do you have a Power of Attorney (POA) ? YES NO Name of POA: _____
(If yes, please provide documentation.)

Home Phone #: _____ Cell # _____

Were you involved in an accident? YES NO
(Please give a brief description of the accident.)

Auto Insurance Name: _____

Address: _____

City, State, Zip: _____

Adjuster's Name: _____

Adjuster's Phone: _____

Claim Number: _____

Policy Holder's Number: _____

With whom may we leave medical information? (Indicate whether or not we may discuss medical information pertinent to your health with this person.)

Name: _____ Relationship: _____ Phone: _____ YES NO

Name: _____ Relationship: _____ Phone: _____ YES NO

Name: _____ Relationship: _____ Phone: _____ YES NO

Signature:

The information recorded is true and accurate and changes in insurance status or income will be reported to CNHC, Inc.

Patient/Guardian Signature _____ Date: _____

Reviewed by Center Staff _____ Date: _____