

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC.
PATIENT PROFILE

PATIENT INFORMATION

Name _____ Patient ID # _____ E-Mail Address _____

Address _____ Date of Birth _____

City, State, Zip _____ Social Security # _____

Marital Status Married Single Divorced Other Sex M F Phone# _____

Employed Yes No Employer Name _____ Phone# _____

Referring Physician _____ Primary Physician _____

Is the patient the responsible party Y N Same as Emergency Contact? Y N

Responsible/Guarantor Party _____ Address _____

Phone # _____

Emergency Contact _____ Phone Number _____

Relationship to Contact Spouse Live-In Parent Other _____

PRIMARY INSURANCE (Please provide a copy of the Insurance, Medicaid or Medicare Card to us.)

Same as Patient Same as Guarantor Other

Insured Party _____

Insured Phone _____

Insurance Company _____

Insurance Group # _____

Relationship to Primary Insured/Guarantor:

Self Other

Social Security # _____

Date of Birth _____

ID # _____

SECONDARY INSURANCE

Same as Patient Same as Guarantor Other

Insured Party _____

Insured Phone _____

Insurance Company _____

Insurance Group # _____

Relationship to Primary Insured/Guarantor:

Self Other

Social Security # _____

Date of Birth _____

ID # _____

UDS 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 _____

Source that Referred you to us _____ If Patient, Name _____

Is the Patient a Vet? Yes No Are you of Hispanic or Latino Descent? Yes No

If you wish to be placed on our sliding fee scale, you will need to provide proof of income to us based upon the rules set forth by the federal government. This information must be supplied every 6 months.

Household Income _____ Weekly Bi-Weekly Monthly Annual

Number Living in Home (Including Patient) _____

Columbus Neighborhood Health Centers, Inc. Treatment/Payment Agreement

I request the above to provide me and/or my family with medical care. I acknowledge my responsibility to pay for that care according to the fees established.

Furthermore, I authorize assignment of benefits for medical/dental/vision services to be paid to Columbus Neighborhood Health Centers, Inc.

THE PRECEDING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Patient/Guardian Signature _____ Date: _____