Pueblo Community Health Center
Your Health. Our Mission.

Patient Information Form

PLEASE PRINT (**ONE** form per person)

Date: _____

Patient Information

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____ Social Security # _____-_____-_____

Sex: ❑ Male ❑ Female ❑ Transgender Male/Female-to-Male ❑ Transgender Female/Male-to-Female ❑ Other ❑ Decline

Physical Address:_____City:_____ State: _____ Zip:_____

Mailing Address: _____City:_____ State: _____ Zip:_____

Phone(s): Day: (____)_____-_____ Cell : (____)_____-_____ Email address: _____

Employer: _____ Work Number: (____)_____-_____

Guarantor Information (Person Responsible for Payment of Accounts/Services)

Same as above ☐

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____ Social Security # _____-_____-_____ Relationship to Patient: _____

Mailing Address: _____City:_____ State: _____ Zip:_____

Phone(s): Day: (____)_____-_____ Cell: (____)_____-_____ Email address: _____

Employer: _____ Work Number: (____)_____-_____

Person to Notify in Case of Emergency (Spouse, Parent, Guardian or Other)

Name: _____Relationship to Patient: _____ Phone: (___) _____-_____

Insurance Information
(Provide current copy of insurance card to PCHC staff)

Name of Insured: _____Name of Insurance_____

Policy Number: _____ Group Number: _____ Policyholder Name: _____

Effective Date: _____ Patient's Relation to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policyholder SSN#:___/_____/_____ Policyholder DOB: _____

Secondary Insurance Name: _____ ID# _____

Is your visit due to a(n): Auto Accident? ☐ Yes ☐ No Job Related Injury? ☐ Yes ☐ No

How did you hear about PCHC?

☐ Family/Friend
☐ Radio/TV
☐ Social Media
☐ Walk-In
☐ Billboard
☐ Other: _____

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Additional Information
Please answer the following questions in order for us to better serve you.

What language is preferred? ☐ English ☐ Spanish ☐ Other _____

Over the past 24 months, have you (patient) or a member of your family:

Been hired to do agricultural work like: planting, picking, packing house, driving truck for any type of farm work, worked with animals like cows, chickens, etc.? ☐ Yes ☐ No

Lived away from home in order to work in any type of agriculture (farm work)? ☐ Yes ☐ No

Stopped working in agriculture because of disability or age (too old to do work)? ☐ Yes ☐ No

Are you presently living with friends or family, in your car, in a shelter, in a hotel or on the street and consider yourself homeless? ☐ Yes ☐ No

US Veteran Status: Have you (patient) completed service in the Uniformed Services of the United States? ☐ Yes ☐ No

Ethnicity: Check one of the following ethnic groups that best pertains to you (patient).

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: Check one of the following racial groups that best pertains to you (patient).

☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American (including Blacks or African American of Latino/Hispanic descent)
☐ American Indian/Alaska Native (including American Indians or Alaskan Natives of Latino/Hispanic descent)
☐ White (including Whites of Latino/Hispanic descent)

Marital Status:

☐ Married (Common Law)
☐ Single
☐ Widowed
☐ Divorced
☐ Other _____

Sexual Orientation:

☐ Lesbian or Gay
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Decline to disclose

Household Size: _____ Monthly Household Income: _____ ☐ Decline to disclose

I hereby certify the information provided is correct and true to the best of my knowledge. I permit PCHC representatives to contact any necessary person or agency to verify this information. I agree to notify PCHC promptly of any change in household members, address, phone, income, insurance, or other essential information. I understand that I must show my card at time of service based upon the guidelines established by PCHC and the State of Colorado. Co-payments/nominal fees are to be made at time of service unless authorized beforehand.

I understand PCHC may request additional information from me in the future to qualify me for programs that will help cover the costs of my care, prescriptions and other services while I am a PCHC patient.

X_____ Date: _____/_____/_____

Signature of Patient (If patient is over 18), GUARDIAN (If patient is under age 18, OR WITNESS (If adult patient is unable to sign)

Print Name: _____

Relationship to Patient: ☐ Self ☐ Parent/guardian ☐ Authorized Representative ☐ Other: _____

Authorized Use Only

Staff initials: _____ Dept: _____

New patient: Yes ☐ No ☐

FPT ☐ FHT ☐ IZ's ☐ AAA Dental ☐ OB Care Only ☐ Podiatry Only ☐
DDS Only ☐ EIS Only ☐ NFP Only ☐ Nursing Home Only ☐

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