



## 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

### Household Income Information

Number of People Living in Household: \_\_\_\_\_

Estimated Monthly Household Income: \$ \_\_\_\_\_ (If no income, please enter "0")

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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

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: \_\_\_\_\_

**How did you hear about PCHC?**

Family/Friend

Radio/TV

Social Media

Walk-In

Billboard

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