



Name: \_\_\_\_\_

ID: \_\_\_\_\_

DOB: \_\_\_\_\_

### Crider Health Center Medical Services Patient Information

Today's Date: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_ Relationship to Patient:  self  parent  other \_\_\_\_\_

How did you hear about us:  family/friends  yellow pages  newspaper  other \_\_\_\_\_

#### Instructions

Please answer the following questions regarding yourself, or if you are representing a child, about the child.

#### Personal Demographic Information

Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Male  Female

Social Security#: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status:  never married  married  separated  divorced  widowed

Race/Ethnicity:  Asian  Pacific Islander  Black/African Amer.  Amer. Indian/Alaska Native  Hispanic/Latino  
 White (non-Hispanic/Latino)  unknown

Preferred Language: \_\_\_\_\_ Any hearing, vision, learning or other disabilities we should be aware of?

If yes, please explain. \_\_\_\_\_

Do you require an additional assistance to help us serve you better?  language interpreter  wheelchair  assistive equipment

(Please explain)

#### Spouse /Parent/ Guardian (if applicable - required if patient is a minor):

Full Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Soc. Security# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Please check if the address is the same

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

#### Insurance Information:

**Insurance Provider:** \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Social Security# \_\_\_\_\_

**Secondary Insurance Provider:** \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Social Security # \_\_\_\_\_

#### Emergency Contact Information:

Name of person not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Work# \_\_\_\_\_ Other# \_\_\_\_\_

I hereby give lifetime authorization for payment of Insurance benefits to be made directly to Crider Health Center for any services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Crider Health Center to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Information Questionnaire

5/5/05

Revised: 8/15/2007

Routing: Front of the form to be copied and routed to AP (Judy Lynch);  
back side will go into the patient file