Your Community HEALTH CENTER

2019 Health Information Update

Today's Date:	YCHC Medical Provider:	YCHC Dental Provider:

PATIENT INFORMATION

Patient Name	MI	Last Name	Date of Birth / /	Age

Street Address	City	State	Zip

Email Address	SSN - -

Phone Number ( ) -	Preferred Pharmacy	Employed ☐ Yes ☐ No Employer Name

Dental Insurance	Primary Insurance	Co-Pay

☐Parent ☐ Guardian ☐ Spouse Name:	Address: ☐ Same as Above	Phone Number ( ) -

IN CASE OF EMERGENCY

Name of Friend or Relative	Relationship to Patient	Primary Number ( )	Secondary Number ( )

PERSON(S) WHO MAY ACCOMPANY MINOR & MAKE DECISIONS FOR MEDICAL/DENTAL/ BEHAVIORAL TREATMENT

Name:	Relationship:	Phone:
1.		
2.		
3.		

PERSON(S) WHO MAY OBTAIN MY HEALTH INFORMATION FROM YCHC

Name:	Relationship:	Phone:
1.		
2.		

PATIENT HEALTH HISTORY

Have you had any changes in your health in the past twelve months?
If so, please list below.

Family History	Diabetes	Hypertension	Heart Dis.	Stroke	Mental Illness	Cancer
Father						
Mother						

Number of brothers	Number of sisters
Number of sons	Number of daughters

Medications (Include prescription and over the counter)

Patient Signature:_____ Date: _____

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	Initial Below
CONSENT FOR TREATMENT: I, the undersigned, do consent for treatment as deemed necessary by the attending health care provider. I, the undersigned, do also consent to treatment by YCHC dental providers	
ALL CHARGES ARE DUE AT THE TIME THAT SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE VISIT. I authorize ***Your Community Health Center*** to release any medical information necessary to process claims and further authorize payment of medical benefits payable directly to ***Your Community Health Center.*** I understand that ***Your Community Health Center*** will file and complete the necessary steps to collect my insurance payment. However, if my insurance doesn't respond or payment is not made within 90 days, I understand that it is my responsibility to pay for any services rendered by ***Your Community Health Center.*** I further understand that ***Your Community Health Center*** may not be contracted with my insurance plan and I agree that I am responsible for charges denied for such reasons.	
Receipt of Our Missed Appointment Policy. I, the undersigned, do acknowledge receipt of the Visit Policy and will make every effort not to miss scheduled appointments and will notify YCHC with 24 hours' notice when I need to cancel an appointment.	
CONSENT FOR TREATMENT OF A MINOR. By signing this consent I represent that I have the legal responsibility for and authority to direct the medical treatment of the above patient, either as parent or legal guardian and I will hold harmless any attending physician or other person or entity against any claim that medical treatment provided to the above patient was not authorized. This consent includes this and subsequent office visits for which I bring this minor to this office. My permission also extends to releasing this medical record to consulting physicians if ever required to adequately diagnose and treat this minor.	
I consent for contact by telephone or text message or email for Appointment Reminders.	
Privacy Notice. I have been offered a copy of my rights to privacy of my protected health information.	
Patient Rights and Responsibilities. I have received a copy of YCHC's Patient Rights and responsibilities.	
Patient Portal Information Sheet. I have received a copy of YCHC's Patient Portal Letter.	
By signing below and initialing on the above lines, I have read and understand the above. **Patient Signature: _____Date: _____**	

For Office Use Only

I have reviewed the patients chart at time of yearly review and verified the following documents are current.

☐ Photo ID ☐ Insurance Information (Including scanned copy) ☐ Sliding Fee Application

☐ Proof of income

Reason not obtained _____

By signing below I acknowledge that I am an employee of Your Community Health Center and I have witnessed and can verify that the above signatures/initials are of the patient/patient representative.

Employee Signature:_____Date:_____

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