COMMUNITY HEALTH PARTNERS

Established Patient Information: Annual Update

Please complete all information on both sides of this form.

Appointment Date:_____

Patient's Legal Name:_____

Preferred Name: _____ **Social Security Number:**_____

Gender on Birth Certificate: □ Male □ Female **Date of Birth**:_____
Month/Day/Year

Other names you have used: _____

Legal guardian (if under age 18):_____

Mailing Address _____
Address or P.O. Box **City** **State** **Zip**

Phone _____ **Email** _____

Marital Status:_____

If Employed, Employer: _____ **Employment Status:** □ Full time □ Part time

Are you a Veteran? □ Yes □ No

In the past two years, have you: 1. Moved to a new location to do farm or ranch work? □ Yes □ No
2. Done farm or ranch work on a seasonal basis? □ Yes □ No

In the past year have you lived in a shelter, halfway house, in your vehicle or on the street, or temporarily lived with family or friends? □ Yes □ No

Sexual Orientation:
□ Lesbian, gay or homosexual
□ Straight or heterosexual
□ Bisexual □ Something Else
□ Don't Know □ Choose not to disclose

Gender Identity:
□ Male □ Female
□ Transgender Male: Female-to-Male
□ Transgender Female: Male to Female
□ Other □ Choose not to disclose

Emergency Contact: _____ **Phone Number:** _____

Emergency Contact's Relationship to you: _____

Who is responsible for today's charges? (adult 18 or older) □ Self □ Other (Is a family member or employer responsible for today's charges?)
Only complete this information for the responsible party if you checked "Other" above:

Name: _____ Relationship to you:_____

Address: _____

Social Security #_____Phone: (H) _____ (W) _____

Date of Birth _____ Employer _____
Month/Day/Year

BusOfficeDoc

SCAN:
Doc Type: Business Office Doc
Doc Desc: CHP Annual Update
E Label

OVER →

□ **I am on CHP's slide and my charges for today should be discounted using the sliding fee scale.**

Do you have insurance that can help pay for today's visit? (Please check all that apply)

□ Private Insurance □ Medicaid □ Medicare □ Healthy Montana Kids
□ Workers' Comp □ Auto Coverage

Policy Holder Name: _____ Policy Holder's Birth Date: _____ Month/Day/Year

Insurance Company:_____ Insurance ID Number: _____

Policy Holder Address: _____

Please provide your insurance card with this form. If you don't have your insurance card with you today, please bring it in as soon as possible or you will receive a bill for the full charge.

Community Health Partners receives some federal funding. Therefore, we are required to ask the following questions. All information will be kept strictly confidential.
This information will be requested one (1) time a year if you are not on a sliding fee discount with us.

Instructions: Start by picking your family size.
Then, pick a **box in that row** that best describes your household income.

What is your annual household income?

Family Size	Income Range	Income Range	Income Range	Income Range
1	❑ $0 to $13,590	❑ $13,591 to $20,385	❑ $20,386 to $27,180	❑ $27,181 and over
2	❑ $0 to $18,310	❑ $18,311 to $27,465	❑ $27,466 to $36,620	❑ $36,621 and over
3	❑ $0 to $23,030	❑ $23,031 to $34,545	❑ $34,546 to $46,060	❑ $46,061 and over
4	❑ $0 to $27,750	❑ $27,751 to $41,625	❑ $41,626 to $55,500	❑ $55,501 and over
5	❑ $0 to $32,470	❑ $32,471to $48,705	❑ $48,706 to $64,940	❑ $64,941 and over
6	❑ $0 to $37,190	❑ $37,191 to $55,785	❑ $55,786 to $74,380	❑ $74,381 and over
7	❑ $0 to $41,910	❑ $41,911 to $62,865	❑ $62,866 to $83,820	❑ $83,821 and over
8	❑ $0 to $46,630	❑ $46,631 to $69,945	❑ $69,946 to $93,260	❑ $93,261 and over
9+	How many people are in your household? _____ What is the combined annual income for all members of your household $_____?			
❑ I choose **not** to provide my family income information.				

Signature _____ Today's Date _____

For Office Use Only
Slide Status: Active □ Date Expired _____
Patient Declined Slide □ Will Return Ppwk by: _____
Entered by_____ Date_____
Double Check _____ Date _____

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