

PATIENT INTAKE FORM

PERSONAL CONTACT INFORMATION			
Legal Name	First:	M.I.	Last:
Address	Street:		Apartment / Unit #
	City:	State:	Zip:
Phone	Home:	Cell:	
Email	Primary email address:		

PATIENT INFORMATION

Date of Birth: ___ / ___ / ___

SSN----- ___

Race:

African American / Black	Caucasian / White	Korean	Nat. American / Alaskan Nat.
Native Hawaiian	Asian Indian	Other Asian	Guamanian
Filipino	Chinese	Samoan	Other Pacific Islander
Japanese	Vietnamese	Chamorro	More than one race

Ethnicity:

Mexican / Chicano	Other Latino, Hispanic, Spanish Origin
Puerto Rican	Combination: Latino, Hispanic, Spanish Origin
Cuban	Not of Latino, Hispanic, or Spanish Origin

Sex on Insurance Card : Male Female

Sex at Birth: Male Female

Occupation:

None	Construction	Hospitality	Education
Agriculture	Custodial / Maintenance	Human Services	Transportation
Business	Government	Manufacturing	Arts & Culture
Computer / IT	Healthcare	Religion	Other

EMPLOYMENT	Employer Name:		
	Address:		
	City / Town:	State:	Zip:
	Work Phone:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
	Patient is a (check all that apply): <input type="checkbox"/> Student <input type="checkbox"/> Veteran <input type="checkbox"/> Migrant / Seasonal Worker		

EMERGENCY CONTACT

Name	First:	Last:
Contact:	Relationship:	Phone:

How did you learn about TCC?: Print Advertisement Web Search Social Media Friend / Family Member
 Radio / TV Employer/School Community Event Other: _____

Patient Name: _____

Patient D.O.B: _____ / _____ / _____

PATIENT HOUSEHOLD INFORMATION

Marital Status: Single Married Separated Divorced Widowed

Which best describes your living arrangement:

Rent / Mortgage Homeless Transitional Homeless Shelter Public Housing / Section 8

Household Size and Income Must Be Completed: Circle the number of members in household. Then circle the total income range.

Percentage of Federal Poverty Guidelines	ANNUAL NET INCOME											
	0 - 100%		101- 125%		126 - 150%		151 - 175%		176 - 200%		Over 200%	
Family Size	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
1	0	\$15,960	\$15,961	\$19,950	\$19,951	\$23,940	\$23,941	\$27,930	\$27,931	\$31,920	\$31,921	and over
2	0	\$21,640	\$21,641	\$27,050	\$27,051	\$32,460	\$32,461	\$37,870	\$37,871	\$43,280	\$43,281	and over
3	0	\$27,320	\$27,321	\$34,150	\$34,151	\$40,980	\$40,981	\$47,810	\$47,811	\$54,640	\$54,641	and over
4	0	\$33,000	\$33,001	\$41,250	\$41,251	\$49,500	\$49,501	\$57,750	\$57,751	\$66,000	\$66,001	and over
5	0	\$38,680	\$38,681	\$48,350	\$48,351	\$58,020	\$58,021	\$67,690	\$67,691	\$77,360	\$77,361	and over
6	0	\$44,360	\$44,361	\$55,450	\$55,451	\$66,540	\$66,541	\$77,630	\$77,631	\$88,720	\$88,721	and over
Each Additional	\$5680											

*Effective Feb 2026

HEALTH INSURANCE STATUS

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? Yes No

If you answered "No", would you like assistance in applying for any of these programs? Yes No

By selecting "Yes", you grant The Chautauqua Center permission to have a Certified Application Counselor / Facilitated Enroller to contact you regarding health insurance.

PRIMARY INSURANCE		
Insurance Name:		
Policy Holder:	Relationship to Patient:	Insurance Phone:
Effective Date:	Policy #	Group #
SECONDARY INSURANCE (if applicable)		
Insurance Name:		
Policy Holder:	Relationship to Patient:	Insurance Phone:
Effective Date:	Policy #	Group #

WORKER'S COMPENSATION / NO-FAULT INJURY

If today's visit is related to a Worker's Compensation injury, please check the box below.

Yes, my visit is related to a worker's compensation injury.

Important: You will need to request and complete a separate intake form for worker's compensation cases. Additionally, please provide verification of your employer's consent for treatment. If you have any questions, please feel free to ask our staff for assistance.

I request that payment of Medicare/Insurance benefits be made on my behalf to The Chautauqua Center for any services furnished to me by that provider. I authorize any holder of any information about to release to the Health Care Financing Administration, its agents, or other insurances any information needed to determine these benefits payable for related services.

SIGNATURE OF PATIENT/GUARDIAN

DATE