PATIENT INTAKE FORM

The Chautauqua Center
Our Family Caring For Your Family

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:	☐ Full Time ☐ Part Time	
	Patient is a (check all that apply): ☐ Student ☐ Veteran ☐ 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	$15,650	$15,651	$19,563	$19,564	$23,475	$23,476	$27,388	$27,389	$31,300	$31,301	and over
2	0	$21,150	$21,151	$26,438	$26,439	$31,725	$31,726	$37,013	$37,014	$42,300	$42,301	and over
3	0	$26,650	$26,651	$33,313	$33,314	$39,975	$39,976	$46,638	$46,639	$53,300	$53,301	and over
4	0	$32,150	$32,151	$40,188	$40,189	$48,225	$48,226	$56,263	$56,264	$64,300	$64,301	and over
5	0	$37,650	$37,651	$47,063	$47,064	$56,475	$56,476	$65,888	$65,889	$75,300	$75,301	and over
6	0	$43,150	$43,151	$53,938	$53,939	$64,725	$64,726	$75,513	$75,514	$86,300	$86,301	and over
7	0	$48,650	$48,651	$60,813	$60,814	$72,975	$72,976	$85,138	$85,139	$97,300	$97,301	and over
8	0	$54,150	$54,151	$67,688	$67,689	$81,225	$81,226	$94,763	$94,764	$108,300	$108,301	and over
Each Additional $5500												

*Effective April 2025

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 to me or 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**