PATIENT INTAKE FORM

The Chautauqua Center
Our Family Caring For Your Family

Today's Date: ____________________ ☐ Annual review ☐ Updating Patient Information

PERSONAL CONTACT INFORMATION			
Legal Name	*First:*	*M.I.*	*Last:*
Address	*Street:*		*Apartment / Unit #*
	City:	*State:*	*Zip:*
Phone	*Home:*	*Cell:*	
Date of Brith		*SSN:*	
For Portal Email	*Primary email address:*		

PATIENT INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Which best describes your living arrangement:

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

PRIMARY INSURANCE		
Insurance Name:		
Policy Holder:	*Relation to Patient:*	*Policy Holder DOB:*
Effective Date:	*Policy #*	*Group #*
SECONDARY INSURANCE (if applicable)		
Insurance Name:		
Policy Holder:	*Relation to Patient:*	*Policy Holder DOB:*
Effective Date:	*Policy #*	*Group #*

No Insurance or under insured? Ask Registration Clerk for Sliding Fee Application

ANNUAL HOUSEHOLD INCOME: (Check box)

☐ $0-5,000 ☐ $5,001-10,000 ☐ $10,001-15,960 ☐ $15961-19,950 ☐ $19,951-23,940 ☐ $23,941-27,930 ☐ $27,931-35,000

☐ $35,001-40,000 ☐ $40,001-45,000 ☐ $45,001-50,000 ☐ Over $50,000 NUMBER OF PEOPLE IN HOUSEHOLD: ______

I am responsible for payment of co-payments, co-insurance, deductibles, sliding fee amounts, as well as any services non-covered by my insurance at the time of my appointment.

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