



COMMUNITY HEALTH SERVICES
OF LAMOILLE VALLEY

Mail to:
Community Health Services of Lamoille Valley
530 Washington Highway, Suite 12, Morrisville, VT 05661

New Patient Information

Last Name: _____ First Name _____ Middle Init _____

Street Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone _____

Work Phone: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: _____ Email Address: _____

Guarantor Name: _____ Phone # _____

Guarantor Address: _____

Insurance Information

Primary Insurance: _____ Phone Number: _____

Insurance Address _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Employer Information

Employer Name: _____ Phone Number: _____

Address: _____

Emergency Contact Name: _____ Phone Number: _____
Pharmacy Name: _____ Pharmacy Number: _____

Additional Information – As a Federally Qualified Health Center we are required to collect the following information:

Race: Please check one

_____ American Indian or Alaska Native _____ Asian _____ Native Hawaiian
_____ Black or African American _____ White _____ Hispanic or Latino
_____ Pacific Islander _____ Other

Ethnicity: Please check one _____ Hispanic _____ Non-Hispanic

Veteran Status: Are you a United States Veteran? _____ Yes _____ No

Income and Household size:

How many people are in your household? _____

Please indicate your approximate annual household income: \$ _____

I respectfully decline to give my household income: Initial here _____

I authorize CHSLV to see, diagnose and treat my medical condition as needed. I accept financial responsibility for all charges incurred as a result of such treatment. If insured, I authorize payment of medical benefits to the named provider for services rendered. I also authorize the release of medical information to process any claims.

Patient or Guardian Signature: _____ Date: _____