Community Health Services of Lamoille Valley
Demographic Information

Patient Information
Primary Language:_____
Patient First Name:_____ Last Name:_____
Physical Address:_____
Mailing Address:_____
Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Marital Status:_____ Email Address: _____
Responsible Party: _____ Responsible Party Relationship to Patient: _____
*If patient is a minor, Name and number of Parent or Legal Guardian:

Insurance Information
Primary Insurance: _____ Insurance Phone Number: (_____)_____-_____
Primary Insurance Address: _____
Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____
Group Number: _____ Subscriber ID: _____

Other Information
Employer Name: _____ Work Phone: (_____)_____-_____
Emergency Contact Name: _____ Phone Number: (_____)_____-_____
Pharmacy Name: _____ Pharmacy Number: (_____)_____-_____

As a Federally Qualified Health Center we are required to collect the following information:
Race: □ Asian □ Black or African American □ Other/Refused to Report
□ White □ American Indian/Alaskan Native □ Native Hawaiian
□ Hispanic □ More than one race □ Other Pacific Islander

Ethnicity: □ Hispanic/Latino □Non-Hispanic □ Refuse to report

Are you a Migrant Worker? □ Yes □ No
Are you a Seasonal Worker? □ Yes □ No
Are you a United States Veteran? □ Yes □ No

Are you homeless? □ Yes □ No
(**If yes**) □ Homeless Shelter □Transitional □ Doubling up □ Street □ Other

The following household information is deidentified and is used to justify our federal funding:
Household size:
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □11 or more

Yearly Household Income (please check one):
□ Less than $22,340 □ $22,341 to $30,260 □ $30,261 to $38,180 □ $38,181 to $46,100
□ $46,101 to $ 54,020 □ $ 54,021 to $61,940 □ $61,941 or more If decline, initial here:_____

I voluntarily authorize healthcare agents and employees of CHSLV and their designees, as may in their professional judgment be deemed necessary or beneficial, to diagnose and treat my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures. 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.
By signing this form I certify that I understand the authorization to treat outlined above and have received the Patient's Bill of Rights and Responsibilities document and the HIPAA privacy information, and I accept these terms.

Patient or Guardian Signature: _____ Date:_____