Community of Hope Health Clinic
CHHC
Volunteers in Medicine

Patient Application & Demographics

Legal Name ______________________________ **Date of Birth** _____ /______ /______
[Your name as it appears on your government issued picture ID] Month Day Year

Social Security Number : ________ - _________ - _________

Address:	**Mailing Address:** (if different from physical address)
______________________ ______________________ ______________________	______________________ ______________________ ______________________
Cell Phone:	**Other Phone:**
E-mail Address:	

Gender	☐ Feminine	☐ Masculine	☐
Race	☐ White	☐ Black or African American	☐ Other:
Ethnicity	☐ Not Hispanic / Latino	☐ Hispanic / Latino	☐ Other:
Preferred Language	☐ English	☐ Spanish	☐ Other:
Preferred Clinic Day (Primary Care Clinic)	☐ Monday Morning 9am-12pm	☐ Tuesday Morning 9am-12pm	☐ Thursday Evening 5pm-8pm

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

Do you have medical insurance? ☐**Yes** ☐**No**	Does your employer (or your spouse's employer) offer health insurance? ☐**Yes** ☐**No**	Have you applied for Disability o SSI benefits? ☐**Yes** ☐**No**
Are you a Veteran? ☐**Yes** ☐**No** Are you eligible for medical benefits at the VA? ☐**Yes** ☐**No**	**Country of Birth**	**Country of Citizenship**

Information about your household – List all of the persons that live with you		
Full Name	Date of Birth	Relationship

Employment Status:	☐ Self-employed ☐ Employed ☐ Unemployed
Employer's Name:	
Employer's Phone Number:	
Position or Type of work:	
Employment Income:	☐ Weekly: $ ___________ ☐ Monthly: $ ____________ ☐ Annual: $ ____________
Other Sources of Income:	

If you are not employed who provides you with financial support? Indicate the full name of the person, their phone number and your relationship with this person..

Patient's Spouse Name:	☐ **None**
Spouse's Phone Number:	
Spouse's Employment Status:	☐ Self-employed ☐ Employed ☐ Unemployed
Spouse's Employer:	
Spouse's Employer Phone:	
Position or Type of work:	
Spouse's Income:	☐ Weekly: $ ___________ ☐ Monthly: $ ____________ ☐ Annual: $ ____________

Emergency Contact Name:	
Emergency Contact Phone:	
Emergency Contact Relationship with Patient:	

Preferred Pharmacy (Name and Phone Number)	

I certify that all the information provided in this form is accurate to the best of my knowledge. I understand that if I provide any false or fraudulent information with this application it could result in permanent suspension from the clinic. If I am accepted as a patient at Community of Hope Health Clinic I agree to follow the clinic's policies and procedures.

Patient Signature: ____ **Date:** ________________

CHHC Office Use Only – Do not write below this area		
Date of Approval:	Re-Certification Due Date:	Staff Name & Initials: