



Please fill out one form for each family member.

Date:

Full name:

If person is a minor, guardian's name:

Date of birth:

Address:

Primary phone number:

If person is a minor, guardian's phone number:

Who referred you to CHCS?

Who is your preferred provider?

1. Why are you seeking healthcare services?

2. What are your current health conditions?

3. What are your current prescription and non-prescription medications?



4. Do you have any drug or food allergies? If so, please list them.

5. If you are requesting obstetrical (OB-GYN) care:
 - a. What was the date of your last menstrual cycle?
 - b. What is your estimated delivery date?

6. Have you ever been to one of our facilities before? If so, when?

7. Who is the most recent doctor or medical provider you have seen for your healthcare needs?

Please be sure to bring a driver's license and insurance card(s) to your appointment.

For internal use only

Was the patient previously dismissed?

Reason:

Approval

Provider:

Provider: