COMMUNITY HEALTH
Centers of Oklahoma
Family Health & Dental Clinics

405.769.3301
Visit: communityhealthok.org
For Our Six Convenient Oklahoma Locations

CONSENT FOR TREATMENT/SERVICES

- Please Complete, Save, Email to registration@communityhealthok.org or Print & Bring To Your Appointment -

Patient Information

Date: _____ Legal Name: _____ Preferred Name (If Different): _____

Date of Birth: _____ Last Four Of Your Social Security #: _____ Sex/Gender: _____

Address: _____ City: _____ State: _____ Zip: _____ Email Address: _____

Telephone Numbers With Area Code: (Home) _____ (Work) _____ (Cell) _____

Ethnicity (Indicate With An X): _____ Hispanic _____ Non-Hispanic Primary/Preferred Language (if NOT English): _____

Race (Indicate With An X): _____ Asian _____ Black _____ African American _____ White _____ Native Hawaiian _____ Pacific Islander

_____ American Indian _____ Alaska Native Other _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Veteran of the U.S. Military? _____Yes _____No Pharmacy Of Choice (Name & Location): _____

How Did You Hear About Us? _____

Responsible Party Information

Name: _____ Account #: _____

Address: _____ Last Four Of Your Social Security #: _____

City: _____ State: _____ Zip: _____ Date Of Birth: _____

Telephone Numbers With Area Code: (Home) _____ (Work) _____ (Cell) _____

Marital Status (Indicate With An X): _____ Single _____ Married _____ Partner _____ Separated _____ Divorced _____ Widowed

Income (Including Spouse's): _____ (Indicate With An X): _____ Weekly _____ Monthly _____ Bi-Monthly _____ Yearly

Family Household Size _____ Salary _____ Social Security _____ Medicaid _____ Unemployment Other: _____

*If Currently Without Income *Receiving Financial Assistance From: Name: _____ Phone: _____

Please provide acceptable documents for proof of income and for proof of legal relationship to child.

*Family (Immediate): **SPOUSE & MINOR CHILDREN ONLY** Additional Page May Be Used for Other Household Members*

	Name: Last / First / Middle	*Sex*	*Date Of Birth*	*Last Four Of Your SS#*	*Birth Parent*	*Guardian*	*Other*	*Race*
1.								
2.								
3.								
4.								

Insurance Information

1. Name Of Insurance: _____

Policy #: _____

Group # _____

PCP: _____

2. Name Of Insurance: _____

Policy #: _____

Group # _____

PCP: _____

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

Please complete both pages of this form

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Initial

I hereby apply for care under this program based on the information given and permit the personnel of Community Health Centers, Inc. to verify any of the information I have furnished.

Initial

I understand that demographic (age, sex, race, income, etc.) information about me and/or my family and information about the number of services that I/we receive may be used without my name or any other information that would individually identify me. This information will assist the Health Center in its efforts to obtain services that will help me/my family and for future planning of services in Oklahoma.

Initial

I hereby authorize the staff and personnel of Community Health Centers, Inc. to perform such diagnosis procedures and other medical/dental procedures as they may deem necessary or advisable from time to time.

Initial

I further authorize Community Health Centers, Inc. to release any appropriate medical information to any hospital to which I/my family may need to be admitted and/or as allowed under the Community Health Notice of Privacy Practices.

Initial

I further understand that if/ have failed to give correct and complete information regarding the questions I have been asked. I/my family as listed is subject to 100% payment billing and subsequently standard collection procedures for delinquent accounts regardless of my payment source.

Initial

I understand that I am responsible for the payment for all services received at the Health Center that are not paid by any other source. I understand that it is fraud to not provide insurance information.

Initial

I understand that by signing this form, my health information will be viewable to my health care providers through MyHealth. I give consent to Community Health Centers, Inc. staff/authorized users to view prescription history in Electronic Health Record, Greenway Health Intergy.

Signature Of Head/Spouse/Guardian: _____ Date: _____

Witness: _____ Date: _____

Please complete both pages of this form