CHS Healthcare/Children's Health Network

Date ____________________

Patient Information

Last	First	Middle	
Home Address	**City**	**State**	**Zip**
Mailing Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Other Phone**	

Sex (please circle) M F	**DOB**	**Social Security #**
Marital Status (please circle) Married Single Other	**Family Size**	**Race** (please circle) (B) Black (W) White (H) Hispanic (O) Other
Residency (please circle) Seasonal Migrant Permanent	**Primary Language Spoken by Patient** (please circle) (C) Creole (E) English (G) Indian Dialect (S) Spanish (O) Other	

Employment Status (please circle) Employed Part Time Student Full Time Student Other:

Employer		Work Phone #	
Work Address	**City**	**State**	**Zip**

Parent Information (if patient is a minor)

Name	DOB	Social Security #	Phone
Mother			
Employer		**Work Phone #**	
Work Address	**City**	**State**	**Zip**

Name	DOB	Social Security #	Phone
Father			
Employer		**Work Phone #**	
Work Address	**City**	**State**	**Zip**

Insurance Information ("Policy Holder" is the one responsible for the insurance premium, e.g., self, parent, spouse.)

Policy Holder Name/Name on Ins. Card		Gender: F / M	DOB:	
Insurance Plan Name		**Plan #**		
Insured ID #	**Ins. Plan Address**	**City**	**State**	**Zip**

Emergency Contact (Other than household member)

Name	Address	City	State	Zip
Phone #	**Relationship to Patient**			

Patient ID

PATIENT REGISTRATION

CHS HEALTHCARE/CHILDREN'S HEALTH NETWORK

I, the undersigned parent or guardian of ____________________________________, hereby authorize CHS Healthcare (Collier Health Services Inc.), the Children's Health Network, its facilities or treatment centers, its affiliated physicians, dentists, surgeons, and other medical personnel in charge of my care, to administer examinations and treatments, as may be deemed medically necessary in the exercise of their professional judgment.

______________________________________ ___________

Signature of Parent or Legal Guardian Date

CONSIENTA PARA el TRATAMIENTO DE UN MENOR

Yo, el padre o el guardián abajofirmantes de _________________________________, por la presente autorizo CHS Healthcare, Children's Health Network, sus centros de facilidades o tratamiento, sus médicos afiliados, los dentistas, los cirujanos, y otro personal médico a cargo de mi cuidado, para administrar exámenes y tratamientos, como se puede creer médicamente necesario en el ejercicio de su juicio profesional.

______________________________________ ___________

Firma del Padre el guardian Fecha

CONSENTIR POUR LE TRAITEMENT D'UN MINEUR

Mwen, antan ke paran ou gadyen sonsignyen, _______________________________, otorize CHS Healthcare, the Children's Health Network, fasilite ou sant de sante, afilye ak fizisyan, dantis, chirijyen, e tout pesonel medical ki responsab de swen mwen, pou administer ezamen e tretman, ki kapab konsidere medikalman nesese nan exzesis jijman pesonel.

______________________________________ ___________

Syiate Paran Dat

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Patient ID

CONSENT FOR TREATMENT OF A MINOR

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CHS Healthcare

I, ____, hereby acknowledge that I have received a copy of CHS's Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by CHS and states my rights with respect to my medical information. I understand CHS has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event CHS revises its information practices, a revised Notice will be posted at CHS Healthcare and that I may obtain a current Notice of Privacy Practices upon request.

Interpreted in: _______________________________________

By: ____ Date __________________

____ __________________

Signature of Patient/ Guardian/ Representative Date Signed

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If Guardian/ Representative, state Relationship to Patient

____ __________________

Signature of Witness Date Signed

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Patient ID

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES