



CLIENT INFORMATION FORM

For Office Use Only

CLIENT DEMOGRAPHIC INFORMATION

Date of Birth ___/___/___ Age ___ SS# _____

First Name _____ MI ___ Last _____

Mailing Address _____

Zip _____ City _____ State _____

Please select 2 methods so we can contact you for test results, visit follow-up, billing, etc.

Cell Phone _____ Texting #? Yes No Home Phone _____ Texting #? Yes No

Work Phone _____ Texting #? Yes No Email _____ Yes No Mail - Yes No

Gender Female Male At birth were you a: Single Twin Triplet Other

Race Alaska Native Asian Black/African American Multi-racial Native American Other Pacific Islander/Hawaiian Unknown White/Caucasian
Ethnicity Hispanic Not Hispanic Unknown

Language English Spanish Other _____ Limited English Proficiency Yes No

Client # _____

Fee Category # _____

Has Ins. Medicaid No Ins.

Chart Ready Time: _____:_____ am/pm

Initials: _____

PARENT/GUARDIAN INFORMATION Mother - Father - Other _____

Date of Birth ___/___/___ SS# _____

First Name _____ MI ___ Last _____

Mailing Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE None Patient's relationship to insured: Self Spouse Child

Insurance Company: _____ Name of Primary Insured: _____

ID#: _____ Group #: _____

Insured Date of Birth: ___/___/___ Insured Phone: _____

Insured's address if different from above: _____

MEDICAID INFORMATION

Name (as printed on card): _____ Medicaid # _____

FOR REPRODUCTIVE HEALTH CLIENTS ONLY

Before our staff can release any information to clients, we will ask for your mother's maiden name and the password you create below.

Mother's Maiden Name: _____ Password _____

TURN PAGE OVER AND COMPLETE THE OTHER SIDE

FOR ALL IMMUNIZATION CLIENTS - PLEASE READ THE FOLLOWING AND INITIAL IF APPLICABLE

_____ I acknowledge that I was given a copy, and I have read, or had explained to me the Central District Health Department Notice of Privacy Practices.

_____ I acknowledge that I was given a copy, and I have read, and understand the Financial and Appointment Policy.

_____ I need financial assistance. My household size _____ My monthly income _____

*****Monthly gross income (DO NOT LEAVE BLANK, DO NOT ENTER 0)*****

_____ I understand that childhood immunizations are not mandatory and may be refused on religious or other grounds.

_____ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208.334.5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

Signature of person receiving vaccine or the person authorized to make the request:

PARENT/GUARDIAN SIGNATURE _____ DATE _____

FOR ALL REPRODUCTIVE HEALTH CLIENTS - PLEASE READ THE FOLLOWING AND INITIAL

_____ I have read and acknowledge Central District Health Department's **Notice of Privacy Practices**.

_____ I have read, fully understand and agree to the terms included in CDHD's **Financial Policy**. Furthermore, I acknowledge and accept that CDHD does not currently participate in Medicare, PPO, HMO, or Participating Provider Plans. I understand that by choosing not to disclose my finances or use my health insurance coverage, I will be responsible for all fees at time of service. I acknowledge it is my responsibility to know which medical services are covered by my insurance plan.

_____ I have read, fully understand, and agree with the terms included in the **Consent for Services and Authorization to Release Medical Information** by telephone.

_____ I understand and acknowledge that I may incur laboratory fees if I do not meet testing criteria, and payment will be expected at time of service for lab testing.

SIGNATURE _____ DATE _____