CENTRAL DISTRICT HEALTH DEPARTMENT

MAIN OFFICE *707 N Armstrong Place, Boise, ID 83704-0825 (208) 327-7400 Fax (208) 327-8579

CLIENT INFORMATION FORM

For Office Use Only

Client #_____

Fee Category #_____

Has Ins. Medicaid No Ins.

Chart Ready Time: ____:____ am pm

Initials: _____

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

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 _____