NORTHWEST CHC Community Health Center

320 East 2nd Street, Libby, MT 59923
Phone: 406-283-6900
Fax: 406-293-6622

To help prevent **Identity Theft** it is the policy of NWCHC that we verify your mailing address and phone number at **EVERY** appointment.

Childs First Name_____ **MI**____ **Last Name**_____ **DOB**_____

Mailing Address_____**City:**_____**State**____ **Zip**_____

Physical Address_____ **City:**_____ **State**____**Zip**_____

Social Security #_____-____-_____ **Gender:** (M) (F) (Transgender: Male to Female or Female to Male)

Primary Phone:_____ **Cell?** (Yes) (No) **Cell Phone** *(if different)* _____

Email _____*(Email Required for Patient Portal access – can be same as parent email)*

Preferred Method(s) of Contact (Phone) (Text) (Email) (Letter) **Is the Child Currently Homeless?** (Yes) (No)

Orientation (Gay) (Straight) (Bisexual) (Don't Know) **Ethnicity** (Non-Hispanic) (Hispanic)

Race (White) (Asian) (African American) (Native American) (Native Hawaiian) Other _____

Preferred Language (English) Other_____ **Translator Needed?** (Yes) (No)

Parent, Guardian Information

Mothers Name_____Birthdate_____SS#_____
Address_____Primary Phone_____
Fathers Name_____Birthdate_____SS#_____
Address_____Primary Phone_____
Legal Guardian_____Birthdate_____SS#_____
Address_____Primary Phone_____
Relationship to pt:_____Guardianship expires:_____

******Proof of guardianship is required***

Insurance Coverage: Medicare Medicaid Other:_____*** Please present card at check-in**

Retail Pharmacy_____ **Mail Order Pharmacy**_____

Please check the box next to the gross income range for your household size.

Family Size					
1 person→	☐$0 - $12,880	☐$12,881 - $19,320	☐$19,321 - $25,760	☐$25,761 - $32,200	☐ABOVE
2 people→	☐$0 - $17,420	☐$17,421 - $26,130	☐$26,131 - $34,840	☐$34,841 - $43,550	☐ABOVE
3 people→	☐$0 - $21,960	☐$21,961 - $32,940	☐$32,941 - $43,920	☐$43,921 - $54,900	☐ABOVE
4 people→	☐$0 - $26,500	☐$26,501 - $39,750	☐$39,751 - $53,000	☐$53,001 - $66,250	☐ABOVE
5 people→	☐$0 - $31,040	☐$31,041 - $46,560	☐$46,561 - $62,080	☐$62,081 - $77,601	☐ABOVE
6 people→	☐$0 - $35,580	☐$35,581 - $53,370	☐$53,371 - $71,160	☐$71,161 - $88,950	☐ABOVE

If more than 6 people – What is the Family Size_____ and income _____

Emergency Contact Information –Must be a number other than the primary phone listed above.

Name:_____ Relationship_____ Phone:_____

I authorize treatment of the above named & certify that the information I have provided is true and correct. I further authorize the release of any medical information necessary to process any insurance claim, and I authorize my insurance benefits to be paid directly to the doctor. I also understand that I am financially responsible for any balance due.

Signature of Parent or Guardian_____Date_____

Printed Name and Relationship to Patient_____