CHP Berkshires

Patient Demographics Form

Legal Last Name	Legal First Name	Legal Middle Name	First Name Used	Suffix

Previous First/Last Name	Legal Sex ☐ Female ☐ Male	Date of Birth:

Physical Address	City	State	ZIP

Mailing/Alternate Address	City	State	ZIP

Home Phone	Mobile Phone ☐ None	Consent to Text ☐ Yes ☐ No

Work Phone	Email Address ☐ None	Contact Preference ☐ Home Phone ☐ Mail ☐ Mobile Phone ☐ Work Phone ☐ Portal

What is your preferred language? ☐ English ☐ Español ☐ Русский ☐ Other (Specify): _____
☐ Choose Not To Disclose

PREFERRED PHARMACY/LAB

My Preferred Pharmacy is:	Phone Number:

Address:	Authorization to Obtain Medication History (downloaded from Pharmacy Benefit Manager Database) ☐ Yes ☐ No
My Preferred Lab is:	**Location:**

What is your race or origin (check all that apply)?
☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White ☐ Other ☐ Decline to answer

What is your ethnicity (select one)? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

What is your marital status? ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Widowed ☐ Separated

What is your sexual orientation?
☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Don't know
☐ Something else (specify): _____ ☐ Choose not to disclose

What is your gender identity? ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male (FTM)
☐ Transgender Female/Male-to-Female (MTF) ☐ Gender non-conforming (non-binary)
☐ Other (please specify): _____ ☐ Choose not to disclose

Assigned sex at birth: ☐ Male ☐ Female ☐ Choose not to disclose

What are your preferred pronouns? ☐ He/Him ☐ She/Her ☐ They/Them

Are you an agricultural worker? ☐ No ☐ Migratory ☐ Seasonal

Do you live in public housing? ☐ Yes ☐ No **Are you a WIC participant?** ☐ Yes ☐ No

Are you homebound? ☐ Yes ☐ No **Are you a Veteran?** ☐ Yes ☐ No ☐ Decline to answer

Who is/are your usual provider(s)?

Consent to call - may we send automated messages to your cell phone? ☐ Yes ☐ No

How did you hear about us? ☐ PCP ☐ Advertising ☐ Specialist ☐ Word of mouth ☐ Another patient ☐ Hospital ☐ Insurance company ☐ CHP employee ☐ Other (specify: _____)

How would you like your Patient Care Summary? ☐ Portal ☐ Mailed to me ☐ Other: _____

Would you like a copy of the Notice of Privacy Practices (posted in the waiting room)? ☐ Yes ☐ No

INSURANCE INFORMATION

Please give the front desk your insurance card so we may have a copy on file. Please complete the insurance information below to ensure billing accuracy. If you have more than two insurances, please notify the front desk.

Primary Policy Holder Last Name **First Name** **Middle Initial** **Suffix** **Date of Birth**

Primary Policy Holder Social Security Number **Phone** **Email Address**

( )

Primary Policy Holder Mailing Address **City** **State** **ZIP**

Secondary Policy Holder Last Name **First Name** **Middle Initial** **Suffix** **Date of Birth**

Secondary Policy Holder Social Security Number **Phone** **Email Address**

( )

Secondary Policy Holder Mailing Address **City** **State** **ZIP**

Medical/Dental Insurance #1	Medical/Dental Insurance #2
Insurance Name **Insurance Plan Type** ☐ Primary ☐ Secondary	**Insurance Name** **Insurance Plan Type** ☐ Primary ☐ Secondary
Member ID Number **Plan/Group Number**	**Member ID Number** **Plan/Group Number**
Effective Date	**Effective Date**

GUARANTOR INFORMATION

Please fill out the information regarding the person responsible for paying bills not covered by the patient's insurance. This may or may not be the policy holder of the insurance.

Please check this box if guarantor is the patient and sign below as guarantor: ☐

Guarantor Last Name **First Name** **Middle Initial** **Suffix** **Date of Birth**

Patient's Relationship to Guarantor: ☐ Child ☐ Other (Specify: _____)

Guarantor Social Security Number **Phone** **Email Address**

( )

Guarantor Mailing Address **City** **State** **ZIP**

Guarantor Signature: _____ **Date:** _____

Federally Qualified Health Centers (FQHCs) have requirements in order to receive grant dollars, and one is to report on the income levels of patients we see at CHP. Please fill out the information below for reporting purposes only:

What is your family size: _____	**Family's Gross Income** $_____**per:** ☐ Week ☐ every 2 weeks ☐ Month ☐ Year

INVOLVEMENT IN YOUR CARE

I hereby request the following individual(s) be allowed to participate in my care or payment decision process. I understand that this individual(s) may be given health or payment information about me if I am unavailable or unable to communicate. CHP will act on this information until I revoke or amend this authorization in writing, or, if I am unable to make my own healthcare decisions and my Health Care Proxy is invoked.

Full Name	Relationship	Phone	Information To Be Released: ☐ All ☐ Medical ☐ Dental ☐ Billing ☐ Appointment Scheduled ☐ Other _____
Full Name	Relationship	Phone	Information To Be Released: ☐ All ☐ Medical ☐ Dental ☐ Billing ☐ Appointment Scheduled ☐ Other _____
Full Name	Relationship	Phone	Information To Be Released: ☐ All ☐ Medical ☐ Dental ☐ Billing ☐ Appointment Scheduled ☐ Other _____

☐ **Do not disclose any information to any person.**

Patient Signature: _____ **Date:** _____

CONTACT INFORMATION

Please fill out the pertinent information below:

Guardian Last Name	First Name	Middle Initial	Suffix	Relationship

Guardian Primary Phone	Cell Phone	Work Phone
( )	( )	( )

Primary Emergency Contact Last Name	First Name	Relationship

Primary Emergency Contact Phone	Cell Phone	Work Phone
( )	( )	( )

Next of Kin Last Name	First Name	Relationship

Next of Kin Primary Phone	Cell Phone	Work Phone
( )	( )	( )

EMPLOYER/SCHOOL INFORMATION

Patient's Employer Name:	Employer Full Address	
Employer's Phone ( )	Patient's Occupation	Are you covered under your employer's insurance? ☐ Yes ☐ No
Patient's School Full Name:	School Full Address	
School Phone ( )	Are you covered under your school's insurance? ☐ Yes ☐ No	