 **Patient Demographics Form**

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| **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 |
| **What is your preferred language?** □ English □ Espaῆol □ Pyccknῆ □ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  |
| **Would you like a copy of the Notice of Privacy Practices (posted in the waiting room)?** □ Yes □ No  |

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| **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** |
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| **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** |

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| **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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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  |

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| **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/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **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****( ) ( ) ( )** |

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| **Primary Emergency Contact Last Name First Name Relationship** |
| **Primary Emergency Contact Phone Cell Phone Work Phone****( ) ( ) ( )** |

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| **Next of Kin Last Name First Name Relationship** |
| **Next of Kin Primary Phone Cell Phone Work Phone** **( ) ( ) ( )** |

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| **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   |



**Patient Communication Preferences**

We use an automated reminder call and messaging system to notify you of your upcoming appointments, to inform you when laboratory or other test results have been uploaded to your chart, billing information, and other information we’d like to share with our patients.

For upcoming appointments, you will be contacted up to three business days before your visit and given the opportunity to confirm or change your appointment, and to check-in early from your home to save time on the day of your visit.

 Would you like to take advantage of our Self-Check-In feature? **□ Yes □ No**

The CHP Portal is a secure method for you to access your information, such as visit summaries, results of lab work, imaging, or other tests, or to send a message to your provider or practice. A valid email address is needed to register for the portal, and will then be required whenever you access the CHP Portal.

Would you like to register for the Patient Portal? **□ Yes □ No** **□ Already Registered**

If yes, we will use your email address on the Demographic Information (see page 1)

 unless you provide a different email address here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We would also like to send you other important information, and by answering the following questions, you’ll be letting us know your preferences for receiving this information.

***Consent to received automated phone calls/text messages (****as indicated below):* **□ Yes □ No**

**Please check your preferences for receiving information:**

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| **Information Type** | **Email\*** | **Phone\*** | **Text\*** |
| Health Notifications | □ Yes | □ Yes | □ Yes |
| Appointments | □ Yes | □ Yes | □ Yes |
| Announcements | □ Yes | □ Yes | □ Yes |
| Billing Information | □ Yes | □ Yes | □ Yes |
| Other CHP Informational Materials | □ Yes | □ Yes | □ Yes |

 **If you choose the Text Message option, you will receive an initial text message**

 **which will require a response in order to opt-in to receive future text messages.**

May we leave a voice mail message on your phone or on your answering machine (no confidential information will be disclosed)? □ Yes □ No

Are there any restrictions as to who is allowed to reschedule your appointments? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_