Community Health Care, Inc.

New Patient Information Form

_____
Chart #

Patient Information - Demographics

First Name: _____Middle Initial: ____Last Name: _____Maiden Name: _____

Social Security #:_____ Date of Birth: _____ Gender: ☐ Female☐ Male

Mailing Address: _____ Apt. #_____

City: _____ State: _____Zip Code: _____

What is your Primary Language: ☐English ☐Spanish ☐Vietnamese ☐Other_____

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated ☐Significant Other

Home Phone Number: _____Cell Phone Number: _____

Email Address: _____

Emergency Contact Name: _____ Relationship to patient: _____

Emergency Contact Phone Number: _____

UDS

Sexual Orientation/Gender Identity Questionnaire

- Do you think of yourself as:
  ☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose
- Do you think of yourself as:
  ☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female)
  ☐ Other, please specify: _____☐ Choose not to disclose
- What sex were you assigned at birth on your original birth certificate?
  ☐ Male ☐ Female ☐ Decline to Answer

Other Questions

- Are you Migrant Worker: ☐Yes ☐No
- What is your Race: ☐African American ☐White ☐ Multiracial ☐Asian ☐Hawaiian Native American
  ☐Indian/Native Alaskan ☐Other Pacific Islander ☐Other: _____
- Are you Hispanic Latino: ☐Yes ☐No
- Are you a Veteran/Military: ☐Yes ☐No

Billing Information

Do you have insurance? ☐Yes ☐No If Yes, what type: ☐Private Insurance ☐Medicaid ☐Medicare

If you have Private Insurance, please fill in the Insurance Policy holder information below if different from the Patient.

Insurance Policy holder Name: _____ DOB: _____Social Security #_____

Mailing Address: _____Apt. #_____

City: _____ State: _____Zip Code: _____