



## Patient Information Form

### Patient Information – Demographics

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_ Last Name: \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Preferred Pronouns:  he/him/his  she/her/hers  they/them/theirs  xe/xem/xyr  ze/hir/hirs  ey/em/eirs  
 ve/vir/vis  Other  Name only  Decline to answer  
 Date of Birth: (Month)\_\_\_\_ (Day)\_\_\_\_ (Year)\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Sex:  Male  Female  Decline to answer  
 Mailing Address: \_\_\_\_\_ Apt: \_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_  
 What Language do you speak at home?  English  Spanish  Vietnamese  Other \_\_\_\_\_  
 Marital Status:  Married  Divorced  Widowed  Single  Separated  Significant Other  
 Primary Phone Number: \_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

### In Case of Emergency:

Emergency Contact Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Emergency Contact Phone Number: \_\_\_\_\_

### UDS

**Is the patient a Migrant Worker:**  Yes  No? **Is the patient Homeless:**  Yes  No?  
**Race:**  Black/ African American  White  Asian Indian  Chinese  Filipino  Japanese  Korean  
 Vietnamese  Other Asian  Native Hawaiian  Other Pacific Islander  Guamanian or Chamorro  
 Samoan  Native American  Alaska Native  Unreported/Choose not to disclose race  
**Ethnicity:**  Mexican, Mexican American, Chicano/o  Puerto Rican  Cuban  Another Hispanic, Latino/a or Spanish origin  
 Not Hispanic, Latino/a or Spanish origin  Unreported/ Choose not to disclose ethnicity  
**Veteran/Military:**  Yes  No?

### Insurance and Billing Information

Do you have insurance?  Yes  No If Yes, what type:  Private Insurance  Medicaid  Medicare  
 Primary Medical Insurance: \_\_\_\_\_ Dental Insurance: \_\_\_\_\_  
**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: \_\_\_\_\_

### For Minor Patients ONLY – Parent/Legal Guardian Responsible for Payments

Guarantor Name: \_\_\_\_\_ Guarantor DOB: \_\_\_\_\_

- The above information I provided is true.
- I give my permission to release of health/financial information that is needed to conduct audits and/ or process insurance claims including: HIV, mental health, STDs, genetic testing, and drug abuse.
- I agree to notify CHC Immediately should there be a change in demographics, insurance coverage, etc.

Please sign here.

**Patient Signature or Parent/Legal Guardian Signature**

**Date**