ADULT PATIENT DEMOGRAPHICS

PATIENT FIRST NAME	PATIENT MIDDLE NAME	PATIENT LAST NAME & SUFFIX
SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/CCYY)	SEX
STREET ADDRESS | CITY | STATE | ZIP		
PRIMARY PHONE & TYPE (I.E. CELL, HOME)	ALTERNATE PHONE &TYPE (I.E. CELL, HOME)	E-MAIL ADDRESS

***If you do not wish to be contacted for confidential reasons, please alert reception*

PRIMARY LANGUAGE:	☐	English	☐	Spanish	☐	Other:				
MARITAL STATUS:	☐	Divorced	☐	Domestic Partner	☐	Separated	☐	Married	☐	Single	☐	Widowed
STUDENT STATUS	☐	Not a Student	☐	Full-Time Student	☐	Part-Time Student						

PATIENT CONTACTS

IN CASE OF EMERGENCY	RELATION	TELEPHONE NUMBER
OTHER PHYSICIAN	SPECIALTY	TELEPHONE
OTHER PHYSICIAN	SPECIALTY	TELEPHONE

ADDITIONAL DEMOGRAPHICS

RACE

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Pacific Islander
- ☐ White
- ☐ Decline to Specify

HOMELESS STATUS

- ☐ Not Homeless
- ☐ Shelter
- ☐ Street
- ☐ Other

LANGUAGE NEEDS

Do you require an interpreter? ☐ No ☐ Yes

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify

VETERAN STATUS

☐ Veteran ☐ Not a Veteran

INCOME

As a Federally Qualified Health Center, we are required to obtain family size & income on all patients. While insured patients may feel uncomfortable completing this section, your cooperation is most appreciative and will help us serve other patients in the community who are in need. For insured patients, income data will be reported to the federal government; however your name will not be associated with it. For uninsured or under-insured individuals, this information will be used to calculate your discount.

GROSS INCOME AMOUNT: _____

☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annual

FAMILY SIZE SUPPORTED BY THIS INCOME

# of Adult(s)	
# of Children	

For Office Use Only:

Proof of Income Source (sliding scale only)

☐ Employment	☐ Child Support	☐ Other:
☐ Social Security	☐ Alimony	
☐ Unemployment	☐ TANF / FIP	

MEDICAL INSURANCE

PRIMARY MEDICAL INSURANCE NAME:	SECONDARY MEDICAL INSURANCE NAME:
POLICY NUMBER:	POLICY NUMBER:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER DOB:	SUBSCRIBER DOB:

DENTAL INSURANCE

DENTAL INSURANCE NAME:	POLICY NUMBER:
SUBSCRIBER NAME:	SUBSCRIBER DOB:

PATIENT SIGNATURE: _____ TODAY'S DATE: _____