Date ______________________ Patient ID:______________

DELHI COMMUNITY HEALTH CENTER
PATIENT INFORMATION FORM: MEDICAL-BHI 2020

Last Name ________________________ First Name ___________________ MI _____ Jr. Sr. III

Mailing Address ____

Address City State Zip

Physical Address ____

Date of Birth _______________ SSN ______ - ______ - ______ E-Mail ______________________________

Home Phone # ________________ Cell Phone # ___________________ Work Phone # ________________

School ____Grade:_____________________________

Pharmacy ____

Dentist ____ ☐ Please check if you do not have a Primary Dentist

Consent to receive calls: Yes No Consent to receive texts: Yes No

***Children under 18 years of age must be accompanied by an adult. See below for further instructions.**

Primary Guardian: Last Name ______________________________ First Name _______________________

Address __________________________________ City ______________________ Zip Code ____________

Date of Birth _______________ SSN ______ - ______ - ______ E-Mail ______________________________

Home Phone # __________________ Cell Phone # _________________ Work Phone # _______________

Secondary Guardian: Last Name ___________________________ First Name _______________________

Address __________________________________ City ______________________ Zip Code ____________

Date of Birth _______________ SSN ______ - ______ - ______ E-Mail ______________________________

Home Phone # __________________ Cell Phone # _________________ Work Phone # _______________

Patient/Policy Holder Insurance Information

Company Name: ____

Policy or Card #: ____

Policy Holder's Last Name: __________________________ First Name: _____________________

Policy Holder Relationship to Patient:____

Policy Holder's Date of Birth: ______/______/______

Policy Holder's SSN#: _______ - _______ - _______

Policy Holder's Address: ______________________ City: _______________ Zip Code: __________

If Medicaid, PCP (Referring Dr.) ____

Delhi Community Health Center is a Federally Qualified Health Center and is required to collect population data.

Are you a veteran of the military? ❒ Yes ❒ No **Seasonal/Agricultural worker?** □ **Yes** □ **No**

Sex at Birth: Male Female

Gender ID: Male Female Transgender male to female Transgender female to male Choose not to disclose Other

Sexual Orientation: Lesbian Gay or Homosexual Straight or heterosexual Bisexual Something else Don't know Choose not to disclose

Race *(check one)* ❒ White ❒ Black ❒ Hispanic ❒ Asian ❒ American Indian/Alaska Native ❒ Pacific Islander ❒ Other

Ethnicity *(check one)* ❒ Hispanic ❒ Non-Hispanic

What is your marital status? *(check one)* ❒ Single ❒ Married ❒ Separated/Divorced ❒ Widowed

Housing Status *(check one)* ❒ Homeless ❒ Doubled Up ❒ Street ❒ Transitional ❒ N/A

How many people live in your household? ___________________________

Transportation Needs: How are you transported to appointments? ____

Who can we contact in case of emergency?

Last Name ____ First Name ____

Address ____Phone # ______________________ Relationship to You _________________

Please ask us about our sliding fee discount program!

Baseline Income Information

Are you receiving any one of the following benefits? (We must have copies of any that are marked yes to be eligible for our sliding fee discount program.)

	YES	NO	If so, how much?
Medical Assistance	❒	❒	______________________
State Public Assistance	❒	❒	______________________
SSI / SSDI	❒	❒	______________________
Social Security	❒	❒	______________________
Veterans Retirement/Disability	❒	❒	______________________
Workers Compensation	❒	❒	______________________
Unemployment	❒	❒	______________________

Annual Income in your household

❒ $10,000 - 20,000

❒ $21,000 - 35,000

❒ $36,000 - 40,000

❒ $41,000 - 50,000

❒ $51,000 +

***The following must be completed on all patients under the age of 18:**

- Are parents: Married/Civil Union_________; Separated________; Divorced___________; Living Together__________
- If parents are no longer together, are either of the child's parents remarried: Yes No
- (list any step-parents names)____
- Does the child live with his/her mother: Yes No If yes, does the child live with her: Full Time Part-Time
- Does the child live with his/her father: Yes No If yes, does the child live with him: Full Time Part-Time
- If the minor child's parents are divorced and/or a custody agreement is in place, please state which parent/legal guardian has domiciliary decision-making authority and custody of the minor child:____
- If the minor child's parents or legal guardians are not married or are legally separated, please provide the court custody order or custody agreement that states who has decision-making authority and custody of the minor child.

Patient Signature: ____

Guardian Signature if patient under 18: ____

Date:____Time: ____