DEMOGRAPHIC INFORMATION

CONNECT HEALTH + WELLNESS

CHECK: ☐ BASSETT ☐ RIDGEWAY ☐ DENTAL

Please complete the entire form. Date Form Completed: ________________

Patient Full Legal Name: ____ ☐ Male ☐ Female

Social Security #: ____ Date of Birth _______________________

Mailing Address: ____ City/State/Zip: _______________________

Street Address *(if different)*: _______________________________ City/State/Zip: _________________________

Primary Phone: _________________________________ Cell Phone: __________________________________

Best time to call: ☐9-12 am ☐12-5 pm ☐after 5 pm

Responsible Party: ☐Patient ☐Spouse ☐Parent ☐Other: ____

<u>If patient is under 18, this entire section MUST be completed by parent or guardian:</u>

Guarantor: _______________________________________ Relationship to patient: _______________________

Guarantor's Date of Birth: _______________________________ SS#: __________________________________

Address: *(if different from patient)* ____

City/State/Zip: ____ Phone #: ______________________________

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widow Spouse Name: ________________________

Please check the box that applies to the patient:

☐Employed ☐Unemployed ☐Disabled ☐Supported by friends/family ☐Student

Employer's Name: ____

Emergency Contact Information:

Name: ____ Relationship: ____________________________

Phone #: _________________________ May we discuss your medical information with this person? ☐ Yes ☐ No

Please list any other person you give permission for us to discuss your medical information:

_______________________________________ / ________________________________ / __________________________
Name Relationship Phone Number

_______________________________________ / ________________________________ / __________________________
Name Relationship Phone Number

Do you have an advanced directive? ☐Yes ☐No (If yes, please provide a copy to front desk.)

Do you have medical insurance? ☐Yes ☐No (If yes, please present card to front desk.)

Insurance Name: ____ Policy #: _____________________________

Name of Insured: _______________________________ Patient relationship to insured: ____________________

(OVER)

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Email Address: ____ or ☐Refuse ☐No Email Address

Race: (*Check all that apply*) ☐White ☐Black/African-American ☐Asian ☐American Indian ☐Other: _________________

Are you of Hispanic descent? ☐Yes ☐No

Pt/guarantor's employer: ____
Employer address: ____
Employer phone # ______________________________ ☐Full time ☐Part time ☐Other: _______________
Can we leave a message for you at your work? ☐Yes ☐No

English Speaking? ☐Yes ☐No If no, what is your preferred language: ________ Need an Interpreter? ☐Yes ☐No

Pharmacy name: _______________________________ Address and Telephone Number:_________________________

The following information is for reporting purposes only. No personal identifiable information is ever reported. This information is for the sliding fee scale. We need amount of money made in one year in the household total before taxes and benefits are taken out.

Annual total household income (please check one): **Number of people in household:**___________

The income below is for one person. If the household size is larger, please see the front desk.
☐ 0 - $15,060
☐ $15,210 - $22,590
☐ $22,815.90 - $26,091.45
☐ $26,355 - 29,818.80
☐ $30,120.00 and above

Is your main source of work for you or your family seasonal or migrant farm work? ☐Yes ☐No

Are you a Veteran? ☐Yes ☐No

Are you homeless? ☐Yes ☐No
If yes, where do you stay at night? ☐Shelter ☐Street ☐Friend/Family ☐Other _____________

Sexual Orientation:
☐Straight ☐Bisexual ☐Gay/Lesbian ☐Something Else ☐Don't Know ☐Choose Not to Disclose

Gender Identification:
☐Male ☐Female ☐Transgender Male/ Male to Female ☐Transgender Female/ Female to Male

Any other relevant comments about your health needs:

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Written: 10/2017 Revised: 8/2022; 2/2024