BARTZ-ALTADONNA COMMUNITY HEALTH CENTER

PATIENT INFORMATION SHEET

****** ALL INFORMATION IS REQUIRED *****

First Name	Middle name	Last Name

Date of Birth	Male Gender assigned at birth	Social Security Number

Phone Number (Home◯Cell◯)	◯ Yes ◯ No May we leave a message?	Preferred name (if different than legal name)

Street Address (if homeless type "Homeless")	City, State	ZIP code

Email *(If patient refused type "Refused")*	Hispanic Ethnicity	Race (type all that apply)

No previous experience Veteran status	Annual Income *(If patient refused type "Refused")*	Family Size *(If patient refused type "Refused")*

◯ Yes ◯ No Better Served in language other than English	Preferred Language	Full time Employment Status

◯ Yes ◯ No Need interpreter?		COVID19 Positive Test date

Please fax this completed form and the signed prescription to 866-572-7851

Our staff will be in touch with the patient once received.