DEMOGRAPHIC INFORMATION

CONNECT HEALTH + WELLNESS

CHECK: ☐ BASSETT ☐ RIDGEWAY ☐ DENTAL ☐ PATRICK SPRINGS

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: _____

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

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)

DEMOGRAPHIC INFORMATION

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Email Address: _____ or ☐Refuse ☐No Email Address

Race: (*Check all that apply)* ☐White ☐Black/African-American ☐American Indian or Native Alaskan ☐Asian Indian

☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐Other Pacific Islander

☐Guamanian or Chamorro ☐Samoan ☐Unreported/Choose not to disclose race

Ethnicity: Are you: ☐Hispanic, Latino/a, or Spanish

☐Yes, Mexican, Mexican American, Chicano/a
☐Yes, Puerto Rican
☐Yes, Cuban
☐Yes, Another Hispanic, Latino/a, or Spanish origin. Specify: _____

☐Not Hispanic, Latino or Spanish
☐Unreported/Choose not to disclose

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:

_____

_____

Written: 10/2017 Revised: 8/2022; 2/2024; 2/2025