FD-ALL.002e

Bluebird Health Advocates LLC

(All information is strictly confidential)

Last Name	First	Middle Initial	Birth Date: / /
Street Address	Apt #	City	State Zip
Mailing Address / P.O. Box	Apt #	City	State Zip

Student?: ☐ No ☐ Full Time ☐ Part Time | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner | Veteran: ☐ Yes ☐ No

Cell Phone Number ( )	Day Phone Number ( )	Alternate Phone Number ( )	Primary Language: _____ Ethnicity: ☐ Hispanic ☐ Non Hispanic

E-mail Address:

Birth Sex:	Gender Identity:	Sexual Orientation:	Preferred Pronoun(s):
☐ Male	☐ Male	☐ Lesbian or gay	☐ He, Him, His
☐ Female	☐ Female	☐ Straight (not lesbian or gay)	☐ She, Her, Hers
Current Gender:	☐ Transgender Male / Female-to-Male	☐ Bisexual	☐ They, Them, Theirs
☐ Male	☐ Transgender Female / Male-to-Female	☐ Something else	☐ Ze, Hir
☐ Female	☐ Other	☐ Don't know	☐ Decline to Answer
☐ Undifferentiated	☐ Chose not to disclose	☐ Chose not to disclose	☐ Other

Which of the following groups do you feel you belong to? ☐ American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ Refused to report

Homeless Status: ☐ Not homeless ☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional ☐ Other ☐ Unknown/unreported

Migrant (Agricultural) Worker Status: Are you a farmworker? ☐ Yes ☐ No
If yes, please check appropriate box: ☐ Migrant worker (moves around) ☐ Seasonal worker (stays in place)

Emergency Contact (REQUIRED)	Phone ( )

Responsible Party (Parent, or legal guardian information. If patient is 18 years or older please print the patient's information.)

Last Name	First	Middle Initial		
Street Address	Apt #	City	State	Zip
Mailing Address / P.O. Box	Apt #	City	State	Zip

Home Phone ( )	Annual Income: (We need this information for statistical purposes)
	☐ $24,000 or less ☐ $25,000 to $49,999 ☐ $50,000 to $74,999 ☐ $75,000 to $99,999 ☐ $100,000 or more ☐ Refused to report (Initials _____)

Employer's Name	Employer's Address (street address, city and state)	Phone ( )

Medical Insurance

1 - Primary Insurance Company	ID #	Group #	Address	
Name of Insured	DOB	Insured's Employer		Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other
2 - Secondary Insurance Company	ID #	Group #	Address	
Name of Insured	DOB	Insured's Employer		Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

I hereby voluntarily consent to outpatient care with Bluebird Health Advocates LLC encompassing routine, minor surgical and diagnostic procedures. I furthermore consent to the performance of examination and procedures by the medical staff and their assistants, including physician assistants and advanced practice nurses. I understand that physician assistants and advanced practice nurses are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I agree to the release of medical records and information including those related to medical treatment, surgical procedures, laboratory testing, psychological services and consultations to any person or entity responsible for payment to Bluebird Health Advocates LLC.

Signature of Patient, Parent or Legal Guardian _____ Date _____

Bluebird Health Advocates LLC

I authorize the direct payment of any benefits due to me for the services provided by Bluebird Health Advocates LLC be paid directly to Bluebird Health Advocates LLC

I realize that Bluebird Health Advocates LLC may be billing me and I am ultimately responsible for the balance on my account.

Self Pay Patients: I understand that it is the policy of Bluebird Health Advocates LLC to collect payment for services at the time of service.

Third-Party Collection Agency: If you have not responded to our attempts to reach you about any unpaid balances, we may opt to send your account to a collection agency.

Patient Signature / Parent (For Minor Patient) _____ Date _____

Witness _____ Date _____