Bair Bones Osteopathic
Family Medicine Inc

Date:_____

Patient Demographic Information

Preferred Name:_____ Age:____ Date of Birth:_____
Complete name on identity documents (if different) :_____
Preferred Language (English, Spanish, Other):_____

Phone Number(s)/type:_____
What is your preferred contact method? ⬜phone call ⬜email ⬜SMS/text ⬜mail ⬜patient portal
Do you consent to receive confidential messages (may contain protected health information) via your preferred contact method? ⬜ yes ⬜ no ⬜ secure patient portal only

Home Address (include city, state, and zip):_____
_____
Mailing Address (if different):_____
_____
Email address:_____

Emergency Contact (name, relationship to patient, phone number):_____
_____
Do you give us permission to discuss your protected health information with anyone else **(optional)**? If yes, please write their name(s), relationship to you, and contact number(s):_____
_____

Preferred Pharmacy (name, location, phone number):_____
_____

Do you have health insurance? ⬜ yes ⬜ no. If yes, please provide the following information:

Insurance Carrier and Plan name: _____
Policy Holder's name and relationship (if not self):_____
Insurance ID and Group #:_____
Insurance Phone number and Address: _____
_____

You do not need health insurance to be seen at Bair Bones. All patients will be seen regardless of their ability to pay. If you are ever unable to afford your visit, please just let us know.

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Please mark all that apply:

My gender identity is:

⬜ Woman
⬜ Man
⬜ Trans woman (MTF)
⬜ Trans man (FTM)
⬜ Non-binary
⬜ Genderqueer
⬜ Other:_____

My sex assigned at birth:

⬜ Female
⬜ Male
⬜ Intersex
⬜ Other:_____

Is this the sex listed on your identity documents?

⬜ yes ⬜ no ⬜ some

My preferred pronoun is:

⬜ She/Her
⬜ He/his
⬜ They/them/their
⬜ Other:_____

My marital status is:

⬜ Single
⬜ Married
⬜ Divorced
⬜ Registered Domestic Partner
⬜ Widowed
⬜ Unmarried Partner
⬜ Separated
⬜ Other: _____

My sexual orientation is:

⬜ Lesbian
⬜ Gay
⬜ Bisexual
⬜ Queer
⬜ Heterosexual
⬜ Asexual
⬜ Other: _____

I live:

⬜ In a house, apartment, SRO
⬜ In an RV or vehicle
⬜ In a shelter or hotel
⬜ In a transitional or treatment program
⬜ On the street
⬜ My situation is temporary and/or unstable

⬜ I am Hispanic/Latin@:
⬜ I am not Hispanic/Latin@

My race is:

⬜ Native American and/or Alaskan Native
⬜ Hispanic/Latin@
⬜ Black/African American
⬜ Native Hawaiian/other Pacific Islander
⬜ Asian
⬜ White/Caucasian
⬜ More than one race
⬜ Other:_____

⬜ I am a seasonal agricultural worker
⬜ I am a veteran

Is there anything else we should know about your personal contact or identity information? _____

_____

Patient Name:_____

Signature of Responsible Party: _____Date:_____

Printed name and relationship of Responsible Party if not “Self” (e.g. mother, guardian, etc.):

_____