Patient Demographic Form

OHHS receives Federal grant money to help sustain our clinics and many of the questions are required by the Grant. Thank you.

PART 1 – GENERAL/PERSONAL INFORMATION **TODAY'S DATE: _____**

LAST NAME: _____DATE OF BIRTH _____

FIRST NAME: _____ MIDDLE INITIAL _____

STREET ADDRESS/BILLING ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE _____

PHONE NUMBER: _____ ALTERNATE PHONE NUMBER _____

SOCIAL SECURITY NUMBER: _____ E-MAIL ADDRESS: _____

MARITAL STATUS: ☐MARRIED ☐DIVORCED ☐SEPARATED ☐SINGLE ☐WIDOWED ☐OTHER

SPOUSE NAME: _____ SPOUSE'S DATE OF BIRTH:_____

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE_____

GENDER:
☐MALE
☐FEMALE
☐TRANSGENDER MALE (FEMALE TO MALE)
☐TRANSGENDER FEMALE (MALE TO
☐FEMALE) OTHER
☐CHOOSE NOT TO DISCLOSE

RACE:
☐WHITE
☐AFRICAN AMERICAN/BLACK
☐ASIAN
☐AMERICAN INDIAN/ALASKA NATIVE NATIVE
☐HAWAIIAN
☐OTHER - PACIFIC ISLANDER
☐OTHER - RACE

ETHNICITY:
☐HISPANIC/LATINO
☐NON-HISPANIC/LATINO

LANGUAGE:
☐ENGLISH
☐INDIAN (INCLUDING HINDI)
☐SPANISH
☐OTHER_____

WILL THE PATIENT REQUIRE A TRANSLATOR? ☐YES ☐NO

SEXUAL ORIENTATION (IF YOU ARE 18 YEARS OR OLDER):

- ☐ HETEROSEXUAL (not lesbian or gay)
- ☐ HOMOSEXUAL (lesbian or gay)
- ☐ BISEXUAL
- ☐ SOMETHING ELSE
- ☐ DON'T KNOW
- ☐ CHOOSE NOT TO DISCLOSE

NAME OF PHARMACY YOU USE: _____

PART 2 - EMPLOYMENT

EMPLOYER: _____

EMPLOYMENT STATUS:

- ☐ FULL-TIME
- ☐ PART-TIME
- ☐ SELF-EMPLOYED
- ☐ UNEMPLOYED
- ☐ RETIRED
- ☐ ACTIVE MILITARY

EMPLOYER'S ADDRESS AND PHONE NUMBER _____

ARE YOU A VETERAN? ☐ YES ☐ NO

DO YOU ATTEND SCHOOL? ☐ YES ☐ NO IF YES, ☐ FULL-TIME ☐ NO

PART 3 – HEALTH INSURANCE INFORMATION/RESPONSIBLE PARTY INFORMATION

1. **HEALTH INSURANCE (PLEASE GIVE A CURRENT CARD TO RECEPTIONIST TO COPY)**

CARD HOLDER/MEMBER: FIRST AND LAST NAME _____

STREET ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH:____/____/_____

PHONE NUMBER: _____ RELATIONSHIP TO PATIENT: _____

2. **RESPONSIBLE PARTY (IF PATIENT IS YOUNGER THAN 18 YEARS):**

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

STREET ADDRESS/BILLING ADDRESS: _____

CITY:_____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH OF RESPONSIBLE PARTY: _____/_____/_____ SOCIAL SECURITY NUMBER: _____