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 (CIRCLE ONE): MARRIED DIVORCED SEPARATED SINGLE WIDOWED OTHER

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

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE: _____

GENDER (CIRCLE ONE):
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 (CIRCLE ONE):
HISPANIC/LATINO
NON-HISPANIC/LATINO

LANGUAGE (CIRCLE ONE):
ENGLISH
INDIAN (INCLUDING HINDI)
SPANISH
RUSSIAN
OTHER: _____

WILL THE PATIENT REQUIRE A TRANSLATOR? YES or NO

SEXUAL ORIENTATION (CIRCLE ONE – 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 (CIRCLE ONE):

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

EMPLOYER'S ADDRESS AND PHONE NUMBER _____

ARE YOU A VETERAN? YES or NO

DO YOU ATTEND SCHOOL? YES or NO IF YES, FULL-TIME _____ OR PART-TIME _____

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: _____