FAMILY HealthCare

{Patient Label Here} *Rev.9/6/24*

Patient Information

Patient Name: ______________________________ Date of Birth: ______________________________

Parent Name (if child)______________________________ Parent Name (if child)______________________________

Home Address: ____ Apt #:______________

City, State and Zip: ______________________________ Home Number:______________________________

Email Address: ______________________________ Cell/ Mobile Number:______________________________

Marital Status: ( ) Single ( ) Domestic Partner ( ) Married Gender at birth: ( ) Male ( ) Female

Social Security #: ______________ Primary Language: ______________ Interpreter needed: ( ) Yes ( ) No

Persons in Family/Household: _______ Income Amount: $__________ ( ) Weekly ( ) Monthly ( ) Annually ( ) Decline

Do you have insurance? ( ) Yes ( ) No ****We offer a discount program to those who qualify, ask us for more information.***

Emergency Contact:

Name: ______________________________ Contact Number: ______________________________

Relationship to patient: ______________________________

Guarantor / Person Responsible for Charges (if different then information above)

Name: ______________________ Date of Birth: ______________ Social Security #: ______________

Relationship to Patient: ______________________ Contact Number: ______________________________

Address: ______________________________ City, State and Zip: ______________________________

Employer Name: ______________________________ Employer Phone Number: ______________________________

Primary insurance:	**Secondary Insurance:**
Insurance Company Name: ______________________	Insurance company name: ______________________
Subscriber ID#: ______________________	Subscriber ID#: ______________________
Group ID#: ______________________	Group ID#: ______________________

Additional Information

Race:	**Ethnicity:**	**Are you homeless?**	**Farm Work Status:**
( ) American Indian/ Alaskan Native ( ) Asian Indian ( ) Chinese ( ) Filipino ( ) Japanese ( ) Korean ( ) Vietnamese ( ) Other Asian ( ) Black/ African American ( ) Native Hawaiian ( ) Pacific Islander ( ) Guamanian or Chamorro ( ) Samoan ( ) White ( ) More than one race ( ) Choose Not to Disclose	( ) Hispanic/Latino/Spanish Origin ( ) Mexican, Mexican American ( ) Cuban ( ) Puerto Rican ( ) Other Hispanic/Latino/Spanish ( ) Non- Hispanic or Latino ( ) Choose not to disclose **Veteran Status:** ( ) Yes, Veteran ( ) Not a Veteran	( ) Yes ( ) No *If Yes: Where do you stay?* ( ) Homeless Shelter ( ) Transitional Housing ( ) Doubling Up ( ) Street ( ) Supportive Housing ( ) Other	( ) Seasonal ( ) Year round ( ) Migrant ( ) None of the above **Education Completed:** ( ) High School ( ) College Degree ( ) Graduate Degree ( ) None of the above
	Gender Identity: ( ) Male ( ) Female ( ) Transgender male to female ( ) Transgender female to male ( ) Other/Neither Male or Female ( ) Choose not to disclose	**Do you identify as:** ( ) Straight ( ) Bisexual ( ) Lesbian or Gay ( ) Something Else ( ) Do not know ( ) Choose not to disclose	**Preferred Pronoun:** ( ) He, Him, His ( ) She, Her, Hers ( ) They, Them, Theirs ( ) Other: ______________ ( ) Choose not to disclose

By signing you are verifying all information above is true and correct.

Patient/Legal Guardian Signature ______________________________ **Date:** ______________________