Friends of Family Health Center

As a Federally Qualified Health Center, Friends of Family Health Center is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Not Reported/Refused if you do not wish to answer a specific question. Thank you for choosing Friends of Family Health Center as your health care provider.

Section 1: Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Driver License Number: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner ☐ Other_____

Street Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Primary Language: ☐English ☐Spanish ☐Sign Language ☐Other_____

Communication Needs: Are you hearing impaired? ☐ Yes ☐ No Are you vision impaired? ☐ Yes ☐ No

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Native Hawaiian or Other Pacific Islander ☐Not Reported/Refused to Report

Ethnicity: ☐Latino/Hispanic ☐Non-Latino/Hispanic ☐Not Reported/Refused to Report

Sexual Orientation: ☐Heterosexual/Straight ☐Homosexual/Gay/Lesbian ☐Bisexual ☐Something else ☐Don't Know ☐Not Reported/Refused to Report

Gender Identity: ☐Male ☐Female ☐Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐Other_____ ☐Not Reported/Refused to Report

Section 2: Family Income and Shelter Information

We request income on all patients for governmental reporting purposes.

Income Period: ☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly ☐Quarterly ☐Annually ☐Other_____

Gross Income for Period: $_____Number of Individuals Income Supports:_____

Homeless Status: ☐Not Homeless ☐Homeless Shelter ☐Transitional ☐Doubling Up ☐Street ☐Other

Worker Status: ☐Migrant ☐Not Migrant ☐Seasonal Do you live in Public Housing? ☐ Yes ☐ No

Veteran: ☐Yes ☐No Disabled: ☐Yes ☐No

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Section 3: Patient Insurance Information

Please allow our staff to copy/scan your insurance card.

Primary Insurance Company: _____ Subscriber: ☐ Yes ☐ No

Policy ID: _____ Group #: _____

Policy Holder's Name: _____ Subscriber DOB: _____/_____/_____

Relationship to patient: _____ Subscriber SSN: _____

Secondary Insurance Company: _____ Subscriber: ☐ Yes ☐ No

Policy ID: _____ Group #: _____

Policy Holder's Name: _____ Subscriber DOB: _____/_____/_____

Relationship to patient: _____ Subscriber SSN: _____

Name of responsible person: _____ DOB: _____/_____/_____

(Only If Patient is a Minor or NOT the Subscriber) SSN (Required): _____

Section 4: Employment Information

Employer: _____ Occupation: _____

Address: _____ City:_____ State: _____ Zip Code:_____

Work Phone: _____ Employment Status: _____

Section 5: Emergency Contact

Patient's Relation to Contact: ☐Child ☐Parent ☐Spouse ☐Other: _____

Name: _____

Street Address: _____City:_____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

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Section 6: Preferred Method of Communication

How do you prefer to be reached?: □Mail □Phone □Email □Patient Portal (email address required)

Email Address: _____

Do you want access to your medical information online through our patient portal? ☐ Yes ☐ No

How did you hear about us? □Family □Friend □Social Media □Flyer □Community Event □Other

_____

Print Name

_____ _____

Signature Date

Office Use Only

□ 501 S. Idaho St., La Habra, CA 90631
Telephone: (562) 690-0400 Fax: (562) 690-3182