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 Chose not to disclose if you do not wish to answer a specific question.

ADULTS

Section 1: Patient Information

Legal First Name: _____ Legal Middle Name: _____

Legal Last Name: _____ Preferred Name: _____ ☐ Same as Above

Social Security Number: _____ Date of Birth: _____/_____/_____

Legal Sex: ☐ Female ☐ Male ☐ Nonbinary

Gender Identity: ☐ Female ☐ Male ☐ Genderqueer ☐ Nonbinary ☐ Questioning ☐ Two Spirit ☐ Transgender Female ☐ Transgender Male ☐ Chose not to disclose

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex

Sexual Orientation: ☐ Straight ☐ Asexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Chose not to disclose

Street Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

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

Email Address: _____ ☐ Chose not to disclose

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Domestic Partner ☐Widowed ☐Significant Other

Religion: ☐ No Religious Preference ☐ Refused to Report ☐ Other: _____

Ethnic group: ☐ Hispanic/Latino ☐Non-Latino/Hispanic ☐Don't Know ☐Not Reported/Refused to Report

Race: ☐American Indian ☐Alaska Native ☐Asian ☐Black or African American ☐White ☐Native Hawaiian ☐Other Pacific Islander ☐ Chose not to disclose

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

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

Housing Status: ☐Stable/permanent ☐Group Home ☐Temporary ☐Vehicle ☐Chose to not disclose

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Section 2: Emergency Contact. Must be different from

Relation to Patient: ☐Child ☐Parent ☐Spouse ☐Significant other ☐Grandparent ☐Other: _____

Name: _____ **Preferred Language:** _____

Street Address: _____**City**:_____ **State:** _____ **Zip Code**:_____

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

Section 3: Additional Patient Information

Employment Status: ☐Full Time ☐Part Time ☐Seasonal ☐Self Employed ☐Retired ☐Not Employed

☐Student FT ☐Student PT ☐Active Military Duty ☐Unemployed due to Disability ☐Chose to not disclose

Employer: _____ **Occupation:** _____

Address: _____ **City**:_____

State: _____ **Zip Code**:_____ **Work Phone:** _____

Preferred Language: ☐English ☐Spanish ☐Sign Language ☐Other_____

English Fluency: ☐Excellent ☐Very Good ☐Good ☐Not Good **Needs Interpreter?** ☐ Yes ☐ No

Veteran/Military Status : ☐ Active Duty ☐ Inactive Duty ☐ Reservist ☐ Veteran ☐None

Driver's License Number: _____ **Driver's License State:** _____ **Exp Date:** _____

Communication Needs: Are you vision impaired? ☐ Yes ☐ No ☐Chose to not disclose

Are you hearing impaired? ☐ Yes ☐ No ☐Chose to not disclose

Are you physically Impaired? ☐ Yes ☐ No ☐Chose to not disclose

Accommodation Needs: ☐Contact lenses ☐Glasses ☐Hearing Aid ☐None

Disability Status: ☐ None ☐ Vision disability ☐ Hearing disability ☐ Speech disability

☐ Learning disability ☐ Mental Health disability ☐ Movement disability

Accessibility Needs: ☐ Wheelchair ☐ Walker ☐ Crutches ☐ Cane

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Section 4: Family Income

We request income from all patients for governmental reporting purposes.

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

Income before taxes: $_____ Number of Individuals Income Supports: _____

Section 5: Patient Insurance Information

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

Primary Insurance : _____ Are you the Policy Holder: ☐ Yes ☐ No

Member ID number: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____
(If different than the patient) (If different than the patient)

Relationship to patient: _____ Policy Holder's SSN: _____
(If different than the patient) (If different than the patient)

Secondary Insurance : _____ Are you the Policy Holder: ☐ Yes ☐ No

Member ID number: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____
(If different than the patient) (If different than the patient)

Relationship to patient: _____ Policy Holder's SSN: _____
(If different than the patient) (If different than the patient)

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

(Only If Patient is NOT the Policy Holder) SSN (Required): _____

_____
Print Name

_____ _____
Signature Date

Office Use Only
□ La Habra
□ Tustin
□ Ontario
□ La Puente
□ Pico Rivera