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.

PEDIATRICS

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 ☐N/A

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

Friends of Family Health Center

Section 2: Parent Information

Patient Lives with: ☐Both Parents ☐Mother Only ☐Father only ☐Other :_____

Primary Parent: ☐ Yes ☐ No **Custody Order:** ☐ Yes ☐ No (if yes, please provide a copy)

Relation to Patient: ☐Mother ☐Father ☐Stepparent ☐Legal Guardian ☐Foster Parent ☐Adoptive Parent

First Name:_____ **Last Name:**_____**Date of Birth:** _____/_____/_____

Address: _____ ☐ **Same as patient**

Phone: _____ **Work Phone**:_____ **Preferred Language:** _____

Primary Parent: ☐ Yes ☐ No **Custody Order:** ☐ Yes ☐ No (if yes, please provide a copy)

Relation to Patient: ☐Mother ☐Father ☐Stepparent ☐Legal Guardian ☐Foster Parent ☐Adoptive Parent

First Name:_____ **Last Name:**_____**Date of Birth:** _____/_____/_____

Address: _____ ☐ **Same as patient**

Cell Phone: _____ **Work Phone**:_____ **Preferred Language:** _____

Section 3: Emergency Contact other than the parents listed above

Relation to Patient: ☐Grandparent ☐Aunt/Uncle ☐Sibling ☐Godparent ☐Other: _____

Name: _____ **Preferred Language:** _____

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

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

Section 4: Additional Patient Information

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

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

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

Friends of Family Health Center

Section 5: 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 6: 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