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.

Section 1: Patient Information

Legal First Name: ________________ **Legal Middle Name**: _____________ **Legal Last Name**:__________________

Preferred Name: ____ ☐ **Same as Above**

Social Security Number: ____________________________ **Driver License Number**: _____________________

Date of Birth: _____/_____/______ **Sex at Birth:** ☐ Male ☐Female ☐Intersex

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 ☐Asexual ☐Pansexual ☐Something else ☐Don't Know ☐Not Reported/Refused to Report

Gender Identity: ☐Male ☐Female ☐Transgender Male (F to M) ☐ Transgender Female (M to F) ☐ Transgender (non-binary) ☐Two-Spirit ☐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

Friends of Family Health Center

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:_____________________

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

□ La Habra
□ Tustin
□ Ontario
□ CPSP Clinics