PATIENT INFORMATION

CHECK ONE:___BASSETT FAMILY PRACTICE ____RIDGEWAY FAMILY HEALTH

(Please complete the entire form) **Date Form Completed:_____**

PATIENT FULL LEGAL NAME:________________________________ ☐**Male** ☐**Female**

SOCIAL SECURITY #:_______-_______-_______ **DATE OF BIRTH:** ____________

MAILING ADDRESS: ______________________ **CITY/STATE/ZIP:**______________

STREET ADDRESS ***(if different)*****:**__________________ **CITY/STATE/ZIP:**______________

PRIMARY PHONE # ______________ **CELL PHONE #** ______________

Best time to call: ☐**9-12 am** ☐**12-5 pm** ☐**after 5 pm**

RESPONSIBLE PARTY: ☐**Patient** ☐**Spouse** ☐**Parent** ☐**Other:** ______________________

If patient is under 18, this entire section MUST be completed by parent or guardian:

GUARANTOR: ____________________ **Relationship to patient:**______________

GUARANTOR'S DATE OF BIRTH: ______________ **SSN:**______________

ADDRESS: ***(if different from patient)*** ______________________

CITY/STATE/ZIP: ______________________ **PHONE #** ______________

Marital Status: ☐**Single** ☐**Married** ☐**Separated** ☐**Divorced** ☐**Widow** **Spouse Name:** ______________

PLEASE CHECK THE BOX THAT APPLIES TO THE PATIENT:

☐**EMPLOYED** ☐**UNEMPLOYED** ☐**DISABLED** ☐**SUPPORTED BY FRIENDS/FAMILY** ☐**STUDENT**

EMPLOYER'S NAME: ______________________________________

EMERGENCY CONTACT INFORMATION:
NAME: ______________________________ **RELATIONSHIP:** ______________

PHONE # ______________ **May we discuss your medical information with this person?** ☐**Yes** ☐**No**

Please list any other person you give permission for us to discuss your medical information:

Name	Relationship	Phone Number
	/	/
	/	/

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐**Yes** ☐**No If yes, please provide a copy to the front desk.**

DO YOU HAVE MEDICAL INSURANCE? ☐**Y** ☐**N** ***(If yes, please present card to front desk)***

Insurance Name:______________________ **Policy #:** ______________

Name of Insured:______________________ **Patient relationship to insured:** ______________

(OVER)

Brakes/Coalition/forms/frontoffice/NewPatientPacket/2018 Patient Demographics
Written: 10/2017 Revised: 1/2018

PATIENT INFORMATION

CHECK ONE:___BASSETT FAMILY PRACTICE ____RIDGEWAY FAMILY HEALTH

EMAIL ADDRESS: ____ or ☐Refuse/ ☐No Email Address

RACE: (*Check all that apply)*

☐WHITE ☐BLACK/AFRICAN-AMERICAN ☐ASIAN ☐AMERICAN INDIAN ☐OTHER:______________________

Are you of Hispanic descent? ☐Y ☐N

PT/GUARANTOR's EMPLOYER: ____

EMPLOYER ADDRESS: ____

EMPLOYER PHONE # ___________________________ ☐Full time ☐Part time ☐Other: ______________

Can we leave a message for you at your work? ☐Yes ☐No

ENGLISH SPEAKING? ☐Yes ☐No If no, preferred language:______________Need an Interpreter? ☐Yes ☐No

PHARMACY USED: ___________________________**Location:**___________________________________

The following information is for grant purposes only. No personal identifiable information is ever reported. By providing this information, you help us continue to receive funding to provide services to our community.

Annual total household income (please check one) Number of people in household:__________

☐0-$12,140 (Slide A) ☐$12,141 -$18,210 (Slide B)

☐$18,211 - $21,245 (Slide C) ☐$21,246 - $24,280 (Slide D)

☐$ 24,281 and above No Discount ☐Do not wish to report

Is your main source of work for you or your family seasonal or migrant farm work? ☐Y ☐N

Are you a Veteran? ☐Y☐N

Are you homeless? ☐Y☐N

If yes, where do you stay at night?☐Shelter ☐Street ☐Friend/Family ☐Other ______________

Sexual Orientation:

☐Straight ☐Bisexual ☐Gay/Lesbian ☐Something Else ☐Don't Know ☐Choose Not to Disclose

Gender Identification:

☐Male ☐Female ☐Transgender Male/ Male to Female ☐Transgender Female/ Female to Male

The following information is to help us to better know our patients and their healthcare needs:
Please answer all applicable to your situation.

Why are you coming to BFP OR RFH?

☐My doctor is leaving ☐Affordability/Cost Insurance Network

☐Sick ☐Heard good things about BFP or RFH

Haven't seen MD ☐1-5 years ☐5-10 years Other: ______________________

How did you find out about us?

☐Friends/Family ☐Hospital ☐Health Fair/Education Class

☐TV/Ad ☐Health Connect/FAMIS ☐Other Physician

☐Facebook ☐Other: ____

Any other relevant comments about your health needs:

____

____

Thank you!

Brakes/Coalition/forms/frontoffice/NewPatientPacket/2018 Patient Demographics

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