BOSTON MOUNTAIN RURAL HEALTH CENTER, INC.

First Name: ______________________________ MI: _______ Last Name: __________________________________

Address: __________________________________City_______________ State ________ Zip Code _____________

Date of Birth: _________________________ Social Security #:___________________________________

Cell Phone: _________________ Home Phone: ________________ Email: ________________________________

Employer Name: _________________________________ Work Phone: ____________________________________

Emergency Contact: _________________________Relationship:________________ Phone #:__________________

Minor Information Parent Name ________________________ DOB _____________ SS# ______________________

Parent Contact # __________________________________

Legal Guardian (If Applicable) _________________________________ (VERIFICATION REQUIRED)

- Ethnicity (circle): **Hispanic or Latino, Not Hispanic, Refused to Report**
- Race (circle): **Asian, American Indian/Alaska Native, Black/African American, Native Hawaiian, Pacific**
- **Islander, White, More Than One Race, Unreported/Refused to Report Race**
- Primary Language (circle): **English, Indian, Spanish, Russian, Other**
- Marital Status (circle): **Single, Married, Divorced, Widowed, Legally Separated, Partner, Unknown**
- Veteran (circle): **Yes/No**
- Education Level (circle): **Some High School, GED, High School Graduate, Some College, College Graduate**
- Communication Needs (circle): **Visually Impaired, Hearing Impaired, Cognitive Impairment**
- Gender Identity (Circle): **Male, Female, Transgender Male /Female-to-Male, Transgender Female/Male-to-Female, Other, Choose not to disclose**
- Sexual Orientation (Circle): **Straight (not lesbian or gay), Lesbian or Gay, Bisexual, Something else, Do not know, Choose not to disclose**

*Boston Mountain is a federally funded organization and therefore is required to ask our patients their sexual orientation as well as their gender identity in order to identify and reduce health disparities as well as promote culturally competent care. If you do not wish to disclose this information, please circle choose not to disclose.

Agricultural Worker: Yes/No *(If "Yes," please specify: seasonal, migrant, employed farm worker, unemployed farm worker)* Start Date: ________ Stop Date: __________

Public Housing: Yes/No Start Date: ________ Stop Date: __________

Homeless: Yes/No Start Date: ________ Stop Date: __________

(If "Yes," please specify: homeless shelter, street, transitional, doubling up, other)

<u>Primary MEDICAL Insurance Information:</u> (OBTAIN COPIES OF INSURANCE CARDS)

Name: ______________________________ DOB: _____________ Policy Holder Name: _______________________

Policy Holder SS#: _________________________________ Relationship to Patient: ____________________________

ID#: ____ GROUP#: ____

<u>Secondary MEDICAL Insurance Information:</u>

Name: ____________________________ DOB: _____________ Policy Holder Name: _________________________

Policy Holder SS#: ______________________________ Relationship to Patient: _______________________________

ID#: ___________________________________ GROUP#: ____

<u>Primary DENTAL Insurance Information:</u>

Name: __________________________ DOB: _____________ Policy Holder Name: ___________________________

Policy Holder SS#: ____________________________ Relationship to Patient: _________________________________

ID#: ______________________________________ GROUP#: ____

PREFERRED PHARMACY_____________________________________

I hereby certify that the above information is correct.

____ ________________

Patient or Responsible Party Signature Date

9 /24/15, 6/23/16, 9/17, 1/18, 6/18