BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

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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, Unreported/Refuse to Report
- **Race (circle)**: Asian, American Indian/Alaska Native, Black/African American, Native Hawaiian, Pacific Islander, Other Pacific Islander, White, Unreported/Refuse to Report, More than One 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
- **Transportation Barrier (circle):** Yes,No
- **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)

Primary MEDICAL Insurance Information: **(OBTAIN COPIES OF INSURANCE CARDS)**

Name: _____ DOB: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Relationship to Patient: _____

ID#: _____ GROUP#: _____

Secondary MEDICAL Insurance Information:

Name: _____ DOB: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Relationship to Patient: _____

ID#: _____ GROUP#: _____

Primary DENTAL Insurance Information:

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, 10/19