Isabella Citizens for Health, Inc.

Last Name:	First Name:	First Name Used:
Date of Birth:	Sex at Birth: □ Male □ Female	
Preferred Method of Contact: □ Text □ E-Mail □ Phone	Street Address:	
City:	State:	Zip Code:

Primary Phone:	Secondary Phone:	Secondary Address: (if applicable):

Email Address:	
Emergency Contact Name: Relationship:	Phone Number:
Parent/Guardian Name (if under 18):	Parent/Guardian Phone Number:

As a Federally Qualified Health Center, we are required by the Federal Government to ask more questions than a typical demographic form. We ask about income because our low-income patients may qualify for discounted services. If you have any questions, please feel free to ask.

Primary Language
□ English
□ Spanish
□ Other:

Agricultural Worker
□ Yes
□ No

Are you a Veteran?
□ Yes
□ No

Race
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian
□ Native Hawaiian
□ Other Pacific Islander
□ Guamanian/Chamorro
□ Samoan
□ White
□ Black or African American
□ American Indian/Alaska Native
□ More than one race
□ Decline to answer

Ethnicity
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Decline to answer

If you select Hispanic/Latino, refer to the information below:
□ Mexican, Mexican American, Chicano/a
□ Puerto Rican
□ Cuban
□ Another Hispanic, Latino/a, or Spanish Origin
□ Hispanic Latino/a, Spanish Origin, Combined

Sexual Orientation
□ Straight/heterosexual
□ Lesbian, gay, homosexual
□ Bisexual
□ Don't know
□ Decline to answer
□ Other:

Gender Identity
□ Male
□ Female
□ Trans: Female to Male
□ Trans: Male to Female
□ Genderqueer
□ Decline to answer
□ Other:

Student Status
□ N/A
□ Full Time
□ Part Time

Relationship Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Partner
□ Legally Separated

Living/Housing Situation
□ Are you homeless?
□ Yes
□ No

□ Do you live in public housing?
□ Yes
□ No

Employment Status:
□ Full Time
□ Part Time
□ Not Employed

Employer:

Isabella Citizens for Health, Inc.

Guarantor Information

Guarantor (if not patient)	Relationship to patient:	Birth Date:	
Adress:	Phone:	Employer:	

Primary Insurance

Insurance Name:	Subscriber's Name:
Patient's Relationship to subscriber:	Date of Birth:
Policy #	Group #

Secondary Insurance

Insurance Name:	Subscriber's Name:
Patient's Relationship to subscriber:	Date of Birth:
Policy #	Group #

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Isabella Citizens for Health or insurance company to release any information required to process my claims.

_____ _____

Patient/ Guardian Signature **Date**

Isabella Citizens for Health, Inc.

Patient's Name: _____ **Birth Date**: _____/_____/_____

I have received the following documents and understand the policies outlined within. I have read the policies in their entirety and fully understand the information within relates to me. **(Please initial each line.)**

INITIAL: _____ General Consent for Treatment

INITIAL: _____ Patient and Center Rights and Responsibilities

INITIAL: _____ Missed Appointment & late arrival Policy

INITIAL: _____ I acknowledge I have received the **Notice of Privacy Practices** of Isabella Citizens for Health, Inc.

Release to Family and Friends Involved in Health Care

Isabella Citizens for Health is committed to the protection of your personal medical information. We realize that in today's society your spouse, family members, or close friends may be involved with your care or the payment of your care. In an effort to protect your personal medical information, we need to know the individual(s) you wish to allow our staff to release or discuss your care or the payment of your care with.

The center has my permission to release or discuss my personal medical information concerning the following:

CHECK ALL THAT CAN BE RELEASED:

☐ General Health Care ☐ Billing and Accounts ☐ Medications

☐ Insurance Information ☐ Appointments ☐ ALL Information

Isabella Citizens for Health may release or discuss my personal medical information, as indicated above, with any of the following individuals in person or by telephone.

1) _____ **Relationship:** _____**Phone:** _____

2) _____ **Relationship:** _____**Phone:** _____

3) _____ **Relationship:** _____**Phone:** _____

4) _____ **Relationship:** _____**Phone:** _____

Isabella Citizens for Health, Inc.

Release to Family and Friends Involved in Health Care (continued):

The information disclosed may include information relating to sexually transmitted infections, HIV/AIDS, or other communicable diseases. It may also include information about behavioral or mental health services, treatment, and/or testing for substance use disorders, and genetic testing. Any sensitive information listed above I wish to be **EXCLUDE** will be indicated here:

If you desire our staff to release or discuss any of the above listed items with your spouse, family members, or close friends, you must specifically authorize, in writing, for us to do so. Any Isabella Citizens for Health staff member will assist you. This document shall remain in effect until revised or revoked by you, the patient, or their authorized representative.

_____	_____
Print Name of Patient	**Date**
_____	_____
Signature of Patient or Legal Representative	**State Relationship to Patient**
_____	_____
Signature of Witness	**Date**

Isabella Citizens for Health, Inc.

Patient Name: _____ Date of Birth: _____

Patient Demographics

Please complete the following information to help us better understand our patient population.

All information is kept confidential and is used for reporting purposes only.

If you have any questions, please ask our staff for help.

Family Size:

Family size or household size is described as total number of people under one roof. **Family Size: _____**

Household Income Data:

Definition of gross household income is the total amount of income (before taxes) for anyone in the household ages 19 and older from all sources including salaries, public assistance, unemployment, retirement payments, Social Security, child support, etc.

*****Please circle the correct gross income range for your household.**

$0-$3,644	$105,820-$108,261	$150,590-$162,799
$3,645-$20,349	$108,262-$109,889	$162,800-$183,149
$20,350-$40,699	$109,890-$112,331	$183,150-$203,499
$40,700-$61,049	$112,332-$122,099	$203,500-$223,849
$61,050-$81,399	$122,100-$142,449	$223,850-$244,199
$81,400-$101,749	$142,450-$146,519	$244,200-$264,550
$101,750-$105,819	$146,520-$150,589	Over $264,551