

***WELCOME***

***We are here to help!***

*To better assist you, we ask that you please answer the following questions along with the other forms in this packet.*

**Last Name**: **First Name**:                      **Middle Name**:

**Alias**:                      (nickname/prior name) **Date Form Completed**:

**Client Social Security Number**:                           **Client Date of Birth**:

**Birth Sex** (Assigned at Birth): [ ] Female [ ]  Male

**Current Gender:** [ ] Female [ ]  Male [ ] Undifferentiated

**Gender Identity**: (not required for patients under age 18)

[ ]  Female

[ ]  Male

[ ]  Female-to Male (FTM)/Transgender Male/Trans Man

[ ]  Male-to female (MTF)/Transgender Female/Trans Woman

[ ]  Genderqueer, neither exclusively male nor female

[ ]  Additional gender category or other, please specify:

[ ]  Choose not to disclose

**Sexual Orientation**: (not required for patients under age 18)

[ ]  Straight or heterosexual

[ ]  Bisexual

[ ]  Lesbian, gay or homosexual

[ ]  Something else, please describe.

[ ]  Don’t Know (patient does not know their sexual orientation)

[ ]  Choose not to disclose

**Preferred Pronouns:**

[ ]  She, Her, Hers

[ ]  He, Him, His

[ ]  Other

[ ]  They, Them, Theirs

[ ]  Ze, Hir

[ ]  Asked but unknown

[ ]  Decline to Answer

**Client Address:**

**City, State, Zip:**

**Marital Status:                           Preferred Language:**

**Smoker:** [ ] Yes [ ]  No

**Client Home Number:                           Client Cell Phone:**

**Client Email Address**:

**Preferred Contact Method:** [ ] Home [ ] Cell [ ]  Email

**Notifications for automated appointment reminders: (select only one)**

[ ]  Email

[ ]  SMS (Text)

[ ]  Voice Reminders

[ ]  Opt out

**Medical Insurance:**                           (Provide insurance card to front desk staff.)

**Dental Insurance:**                           (Provide insurance card to front desk staff.)

**Emergency Contact Name:**

**Phone Number:**

**Emergency Contact Relationship to Client:**

**Guardian Name (if you are not your own Guardian):**

**Guardian Relationship to Patient**:

**Guardian Phone Number**:

**Guardian Address**:

**Homeless Status:**

[ ]  Non Homeless

[ ]  Homeless Shelter

[ ]  Doubling Up (living with others, “couch surfing”)

[ ]  Transitional Housing (small unit where people transition from a shelter)

[ ]  Street (living on street, vehicle, outdoors, or encampment)

[ ]  Other (reside in hotel/motel)

**Migrant Worker Status:**

[ ]  Migrant

[ ]  Not a Farm Worker

[ ]  Seasonal Agricultural Worker or Dependent

**Language Barrier**: [ ]  Yes [ ] No

**Race:** (check all that apply)

[ ]  American Indian or Alaska Native

[ ]  Asian Indian

[ ]  Black or African American

[ ]  Chinese

[ ]  Filipino

[ ]  Guamanian or Chamorro

[ ]  Japanese

[ ]  Korean

[ ]  Native Hawaiian

[ ]  Other Asian

[ ]  Other Pacific Islander

[ ]  Samoan

[ ]  Vietnamese

[ ]  White

[ ]  Unreported/Refused to Report

**Ethnicity:**

[ ]  Cuban

[ ]  Mexican, Mexican American, Chicano/a

[ ]  Puerto Rican

[ ]  Another Hispanic, Latino/a, or Spanish origin

[ ]  Not Hispanic or Latino/a

[ ]  Declined to specify

**Veteran Status:** [ ]  Yes [ ] No

**Head of Household**

[ ]  Self

**If not self, Relationship to Patient**

**Head of Household Name:**

**Head of Household DOB:**                           **Head of Household Birth Sex**:

**Head of Household Address:                           City, State, Zip :**

**Phone Number:**

**Number in Household:**

**Annual Income Range:**

[ ]  $0 - $13,590

[ ]  $13,591 - $18,310

[ ]  $18,311 - $23,030

[ ]  $23,031 - $27,750

[ ]  $27,751 - $32,470

[ ]  $32,471 - $37,190

[ ]  $37,191 - $41,910

[ ]  $41,911 - $46,630

[ ]  $46,631 & above

**How were you referred to Compass Health Network?** Marketing Plan:

[ ]  Agency

[ ]  Billboard

[ ]  Friend or Family

[ ]  Internet

[ ]  Newspaper

[ ]  Other Health Provider

[ ]  Radio

[ ]  TV

[ ]  Other**:**