Compass Health Network

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 Phone 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

PLEASE PRESENT YOUR INSURANCE CARD TO FRONT DESK STAFF

Medical Insurance: _____

Subscriber Information – *If someone other than the patient*

Subscriber Name: _____

Date of Birth: _____SSN: _____ Sex: ☐Male ☐Female

Relationship to Patient: _____

Address (if different than patient's): _____

Primary Phone: _____Alternate Phone: _____

Dental Insurance: _____

Subscriber Information – *If someone other than the patient*

Subscriber Name: _____

Date of Birth: _____SSN: _____ Sex: ☐Male ☐Female

Relationship to Patient: _____

Address (if different than patient's): _____

Primary Phone: _____Alternate Phone: _____

Emergency Contact Name: _____

Phone Number: _____

Emergency Contact Relationship to Client:_____

Parent/Guardian (s)	Parent/Guardian 1	Parent/Guardian 2
Name:		
Relationship:		
Address:		
Phone:		
Date of Birth:		

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 : _____

Head of Household 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**:** _____