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: ___________________________Policy/Member ID: ______________________________________

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: ___________________________Policy/Member ID:______________________________________

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**:** ___________________________