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

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: $: _____

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

☐ Agency
☐ Billboard
☐ Friend or Family
☐ Internet
☐ Newspaper
☐ Other Health Provider
☐ Radio
☐ TV
☐ Other**:** _____