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: | | |

I am interested in applying for the sliding scale program. ☐ Yes ☐ No

Employment Status:

☐ Employed Full Time (35 or more hrs/wk)
☐ Employed Part Time (less than 35 hrswk)
☐ Not in Workforce-Disabled
☐ Not in Workforce-Homemaker
☐ Not in Workforce-Inmate
☐ Not in Workforce-Other
☐ Not in Workforce-Preschool
☐ Not in Workforce-Retired
☐ Unknown
☐ Not in Workforce-Student (acad or vocational)
☐ Receiving Support to Seek employment
☐ Seasonal Employment
☐ Seeking Employment
☐ Sheltered Workshop
☐ Supported Employment
☐ Unemployed sought last 30 or on layoff
☐ Unemployed-Lay off
☐ Volunteer

Values under monthly hours worked:

☐ 1-20
☐ 21-40
☐ 41-60
☐ 61-80
☐ 81-100
☐ 100+
☐ None
☐ Unknown

**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**:** _____