SIHF HEALTHCARE

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE NAME | ASSIGNED SEX AT BIRTH

DATE OF BIRTH | SSN

STREET ADDRESS | APT # | CITY | STATE | ZIP

PHONE # | CELL # | EMAIL

LANGUAGE: _____

DO YOU NEED AN INTERPRETOR OR TRANSLATOR? ☐ YES ☐ NO

ETHNICITY: HISPANIC OR LATINO/SPANISH ☐ YES ☐ NO

RACE
☐ WHITE ☐ AMERICAN INDIAN ☐ BLACK
☐ NATIVE HAWAIIAN ☐ ASIAN
☐ PACIFIC ISLANDER ☐ MORE THAN 1 RACE

MARITAL STATUS
☐ SINGLE
☐ MARRIED
☐ DIVORCED
☐ WIDOWED

SEXUAL ORIENTATION
☐ LESBIAN, GAY OR HOMOSEXUAL ☐ BISEXUAL
☐ STRAIGHT OR HETEROSEXUAL ☐ DON'T KNOW
☐ OTHER: _____
☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ TRANSGENDER/MALE
☐ TRANSGENDER/FEMALE ☐ CHOOSE NOT TO DISCLOSE
☐ GENDER NON-CONFORMING
☐ OTHER: _____

FAMILY SIZE
_____ PEOPLE

FAMILY INCOME
☐ A ☐ B ☐ C ☐ D

(SEE INCOME CATEGORIES SCALE)

ARE YOU A MIGRANT AGRICULTURAL WORKER?
☐ YES ☐ NO

ARE YOU A VETERAN
☐ YES
☐ NO

ARE YOU HOMELESS? ☐ YES ☐ NO IF YES, SELECT HOUSING TYPE: ☐ SHELTER ☐ TRANSITIONAL ☐ STREET
☐ DOUBLING UP ☐ SUPPORTIVE HOUSING ☐ OTHER: _____

EMERGENCY CONTACT NAME | RELATIONSHIP | PHONE # | CELL #

EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ UNEMPLOYED ☐ RETIRED

EMPLOYER NAME: _____ WORK PHONE #: _____

PARENT/GUARDIAN OR OTHER PERSON TO BE BILLED (IF DIFFERENT THAN PATIENT)

LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH

STREET ADDRESS | APT # | CITY | STATE | ZIP

FINANCIAL ASSISTANCE

ARE YOU INTERESTED IN RECEIVING ASSISTANCE TO PAY YOUR MEDICAL BILLS WITH SIHF FOR YOU OR A FAMILY MEMBER? ☐ YES ☐ NO

I HAVE INSURANCE BUT WOULD LIKE TO APPLY FOR SMART PAY, SLIDING FEE DISCOUNT, FOR MY DEDUCTIBLE OR COPAY? ☐ YES ☐ NO

OTHER INFORMATION

DO YOU HAVE A HIGH SCHOOL DIPLOMA OR HIGHER EDUCATION? ☐ YES ☐ NO

DO YOU SOMETIMES HAVE TO MISS YOUR MEDICAL APPOINTMENTS DUE TO DIFFICULTY GETTING TRANSPORTATION? ☐ YES ☐ NO

CONSENT

I CONSENT TO RECEIVING COMMUNICATION BY ALL FORMS, INCLUDING AUTO CALLS AND TEXTS ☐ YES ☐ NO

I CERTIFY THAT ALL OF THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE, AND I ACKNOWLEDGE THAT IT IS SUBJECT TO VERIFICATION.

PATIENT/PARENT SIGNATURE: _____ DATE: _____

INSURANCE

☐ INSURANCE CARD COPIED ☐ ID COPIED STAFF MEMBER: _____ DATE: _____