Community Health Center
of the North Country

WATERTOWN HEALTH CENTER INTAKE FORM

Name (Last, First, Middle):		
Today's Date:	☐ M ☐ F	DOB:
Address:		
Phone Number:	Occupation:	
Emergency Contact (Name & Number):		
Primary Care Provider:	Pharmacy of Choice:	
Email Address:		
Marital Status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Sexual Orientation:	☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose ☐ Not Applicable (Patient Under Age 18)	
Gender Identity:	☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose Not to Disclose ☐ Not Applicable (Patient Under Age 18)	
Are you a Diabetic?	☐ Yes ☐ No ☐ Not Sure	

Please check any that apply:

☐	American Indian / Alaska Native
☐	Asian
☐	Native Hawaiian
☐	White
☐	Hispanic Latino
☐	Pacific Islander
☐	African American
☐	Other Race
☐	Do Not Wish to Report

☐	Are you homeless?
☐	Are you a migrant worker?
☐	Have you ever served in the Military?