Community Health Center of the North Country

Annual FQHC Demographic Questionnaire

Date: _____

We are a Federally Qualified Health Center and are required to collect this data.
The following information is for data collection purposes and will not affect your care.

Demographic Information

Legal Name: _____

Previous Name: _____ Preferred Name: _____

Date of Birth: _____

Social Security Number: _____

Mailing Address: _____

City, State, Zip: _____

Email Address: _____

Would you like to be registered for our Patient Portal? ☐Yes ☐No

Phone Numbers	Select Best Number to Use	OK to Leave Voicemail?
Home (_____) _____-_____	☐	☐ Yes ☐ No
Cell (_____) _____-_____	☐	☐ Yes ☐ No
Work (_____) _____-_____	☐	☐ Yes ☐ No

Birth Sex
- ☐ Female
- ☐ Male

Sexual Orientation
- ☐ Bisexual
- ☐ Lesbian or Gay
- ☐ Straight or Heterosexual
- ☐ Other _____
- ☐ Don't Know
- ☐ Choose not to disclose

Gender Identity
- ☐ Female
- ☐ Male
- ☐ Female-to-Male/Transgender Male
- ☐ Male-to-Female/Transgender Female
- ☐ Other _____
- ☐ Choose not to disclose

Income Information - Assists us in reviewing & assessing the Poverty Levels of our entire patient population

What is the ***annual*** household income? $_____ ☐ Choose not to disclose

How many people (including yourself) does this income support? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Other _____

It is the policy of the CHCNC to offer a sliding fee schedule for all patients who are at or below 200% of the poverty level.
Do you wish to speak with someone regarding our sliding fee schedule? ☐ Yes ☐ No

Insurance Information

Primary Medical Insurance

☐ **I do not have Medical Insurance**

Insurance Company Name: _____
Medical Policy #: _____
Policyholder Name: _____
Policyholder Date of Birth: _____
Policyholder Social Security Number: _____

Primary Dental Insurance (Dental Patients Only)

☐ **I do not have Dental Insurance**

Insurance Company Name: _____
Dental Policy #: _____
Policyholder Name: _____
Policyholder Date of Birth: _____
Policyholder Social Security Number: _____

Responsible Party Information - *Person who is responsible for Payment of Patient's Account*

☐ Same as Patient

Name: _____ DOB: _____

Social Security Number: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Relationship to Patient: (*Proof of Legal Status is Required)

___Self ___Parent ___Guardian ___Custodial Parent*

___Foster Parent* Foster Parent Agency _____

Emergency Contact

Name: _____

Phone Number: _____

Relation to Patient:

☐ Spouse ☐ Child ☐ Other Family Member

☐ Neighbor ☐ Friend

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Marital Status
- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Partner
- ☐ Single
- ☐ Widowed

Language
- ☐ English
- ☐ Español
- ☐ Français
- ☐ Other _____
- ☐ Do you need an interpreter? ☐ Yes ☐ No

Racial Group(s)
- ☐ American Indian/Alaska Native
- ☐ Asian Indian
- ☐ Black/African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White/Caucasian
- ☐ Other _____
- ☐ Decline to Specify

Other Characteristic(s)
- ☐ Amish
- ☐ Homeless
- ☐ Individual with a Developmental Disability
- ☐ Migrant Worker
- ☐ Seasonal Worker
- ☐ Veteran
- ☐ None
- ☐ Choose not to report

Ethnicity
- ☐ Chicano
- ☐ Cuban
- ☐ Mexican
- ☐ Mexican American
- ☐ Not Hispanic/Latino
- ☐ Puerto Rican
- ☐ Other _____
- ☐ Decline to Specify

Employment/Education Information

☐ Employed Full-Time ☐ Unemployed ☐ Disabled
☐ Employed Part-Time ☐ Retired ☐ Other

Employer Name: _____

Are you covered by your Employer's Insurance? ☐ Yes ☐ No

☐ Student Full-Time ☐ Student Part-Time

School/College Name: _____

Are you covered by your School's Insurance? ☐ Yes ☐ No

Pharmacy Information

Preferred Pharmacy: _____

City/State: _____

Is it okay to text you appointment confirmations and notifications of prescriptions sent to your Pharmacy?
☐ Yes ☐ No

Consent to Discuss Protected Health Information - Protected Health Information (PHI) means individually identifiable information relating to past, present, or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual. Healthcare Treatment consists of services provided by each discipline within CHCNC: Primary, Mental Health, Dental, Optometry, Physical Therapy, and Foot Care. This consent is limited, and does not include permission to discuss Alcohol/Drug Treatment or confidential HIV/AIDS –related information, which needs a special signed release.

Permission to Accompany for MINOR Patients ONLY (Under Age of 18) The following individual(s) have my permission to accompany the above named minor child to a healthcare appointment at Community Health Center of the North Country. I understand that this person will be privy to PHI. I understand that if an invasive procedure or immunizations are needed I will need to bring the child in or be available for telephone consent.

I give permission to CHCNC to discuss my PHI (or the PHI of the above named patient I'm authorized to consent for) with the following individuals:

			Permission to Accompany Minor to Appointment
Name: _____	Relationship: _____	Phone: _____	☐ Yes
Name: _____	Relationship: _____	Phone: _____	☐ Yes
Name: _____	Relationship: _____	Phone: _____	☐ Yes
Name: _____	Relationship: _____	Phone: _____	☐ Yes

I understand I have the right to revoke these permissions, in writing, at any time, except in regards to actions the Health Center has already taken due to this consent.

Patient/Legal Guardian Print Name: _____ **Signature:** _____

CHCNC OFFICE USE ONLY - I have reviewed with the patient and explained the importance of collecting this information.

Staff Signature: _____ Date: _____