

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.

Legal Name: Preferred Name: Date of Birth:	Demograph	ic Information							
Previous Name: Preferred Name: Social Security Number:	Legal Name:			Date of Birth:					
Maining Adultess: Phone Numbers Number City, State, Zip: Home (I Use Home (I Use Vice transfer Email Address: Cell (I Ves [No Would you like to be registered for our Patient Portal? [Ves [No Work (I Ves [No Birth Sex Sexual Orientation Pronouns Gender Identity I Ves [No Birth Sex Lesbian or Gay I He/Him She/Her Female I Ves [No Birth Sex Straight or Heterosexual He/Him She/Her Female I Ves [No Other Color Know En/En Ey/Em Other Other Other Don't Know En/En Ey/Em Other Other Other Other What is the annual household income? \$			rred Name:						
Home (Phone Numbers		Number			
Linkin Volucies Primary Dental Insurance Gender Identity Birth Sex Sexual Orientation Pronouns Birth Sex Sexual Orientation Pronouns Birth Sex Straight or Heterosexual They/Them Service Other Don't Know Female Female-to-Male/Transgender Male Don't Know En/En Co/Co Other Other Don't Know En/En Cy/Yo VeVis Choose not to disclose Income Information - Assists us in reviewing & assessing the Poverty Levels of our entire patient population Other Choose not to disclose What is the annual household income? \$ Choose not to disclose Choose not to disclose Choose not to disclose Insurance Information Parinery Medical Insurance Primary Dental Insurance (Dental Patients Only) I do not have Baddia Insurance Insurance Company Name: Dental Policy #: Policyholder Name: Policyholder Name: Policyholder Name: Policyholder Name: Dool: Policyholder Name: Policyholder Name: Policyholder Name: Policyholder Name: Dool: Name: Policyholder Name: Policyholder Name: Policyholder Name: <td></td> <td>······································</td> <td>•••••••••••••••••••••••••••••••••••••••</td> <td colspan="2">Home ()</td> <td></td> <td>□ Yes □ No</td>		······································	•••••••••••••••••••••••••••••••••••••••	Home ()			□ Yes □ No		
Would you like to be registered for our Patient Portal? [`Yes]No Work (Email Addres	SS:		Cell ()			□ Yes □ No		
Female Bisexual He/Him She/Her Female Male Lesbian or Gay They/Them Ze/Sir Male Other Hix/Hir Co/Co Male Female-to-Male/Transgender Male Other Don't Know En/En Ey/Em Other Male Hix/Hir Co/Co Choose not to disclose Male Other Male Income Information - Assists us in reviewing & assessing the Poverty Levels of our entire patient population Mole Other Choose not to disclose Income Information - Assists us in reviewing & assessing the Poverty Levels of our entire patient population Choose not to disclose Choose not to disclose Insurance Information Fernary Medical Insurance Choose not to disclose Chore Choose Primary Medical Insurance Insurance Company Name: Dental Policy H Dental Policy H Dental Policy H Dental Policy Name: Dental Policy H Dental Policy H Delicyholder Name: Policyholder Name: Policyholder Name: Policyholder Social Security Number: Policyholder Social Security Number: Policyholder Social Security Number: Policyholder Social Security Number: Relation to Patient: Chon thave Bental Insurance Bitth </td <td></td> <td>••••••••••••••••••••••••</td> <td>· · · · · · · · · · · · · · · · · · ·</td> <td colspan="2">Work ()</td> <td></td> <td>□ Yes □ No</td>		••••••••••••••••••••••••	· · · · · · · · · · · · · · · · · · ·	Work ()			□ Yes □ No		
Male Lesbian or Gay They/Them Ze/Sir Male Straight or Heterosexual They/Them Ze/Sir Female-to-Male/Transgender Male Other En/En Ey/Em Other Male Choose not to disclose Yo/Yo Ve/Vis Other Other Income Information - Assists us in reviewing & assessing the Poverty Levels of our entire patient population What is the annual household income? \$	Birth Sex	Sexual Orientation	Pronouns		Gender Identi	ty			
What is the annual household income? \$		 Lesbian or Gay Straight or Heterosexual Other Don't Know 	☐ They/Them☐ Hix/Hir☐ En/En	□ Ze/Sir □ Co/Co □ Ey/Em	 □ Male □ Female-to-I □ Male-to-Fer □ Other 	 Male Female-to-Male/Transgender Male Male-to-Female/Transgender Female Other 			
What is the annual household income? \$	Income Info	Income Information - Assists us in reviewing & assessing the Poverty Levels of our entire patient population							
Do you wish to speak with someone regarding our sliding fee schedule? Yes No Insurance Information Primary Medical Insurance Primary Dental Insurance (Dental Patients Only) I do not have Medical Insurance I do not have Dental Insurance (Dental Patients Only) Isurance Company Name: I do not have Dental Insurance Insurance Company Name: Dental Policy Policyholder Name: Policyholder Name: Policyholder Date of Birth: Policyholder Date of Birth: Policyholder Social Security Number: Policyholder Social Security Number: Policyholder Social Security Number: Policyholder Social Security Number: Same as Patient Name: Name: DOB: Social Security Number: Phone Number: Phone Number: Policyhold I cont Patient: Phone Number: Spouse Relation to Patient: Spouse Spouse Child Other Family Member Spouse Child Other Family Member Spouse Child Other Family Member	What is the <i>annual</i> household income? \$ Choose not to disclose					ot to disclose			
Primary Medical Insurance Primary Dental Insurance (Dental Patients Only) I do not have Medical Insurance Insurance Company Name: Insurance Company Name: Isurance Company Name: Medical Policy #: Dental Policy #: Policyholder Name: Dental Policy #: Policyholder Date of Birth: Policyholder Name: Policyholder Social Security Number: Policyholder Social Security Number: Policyholder Social Security Number: Policyholder Social Security Number: Same as Patient Name: Name: DOB: Address: Relation to Patient: (*Proof of Legal Status is Required) Self Parent Guardian Self Parent Guardian									
I do not have Medical Insurance I do not have Dental Insurance Insurance Company Name: Insurance Company Name: Medical Policy #: Dental Policy Name: Policyholder Name: Dental Policy #: Policyholder Date of Birth: Policyholder Name: Policyholder Social Security Number: Policyholder Date of Birth: Policyholder Social Security Number: Policyholder Social Security Number: Responsible Party Information - Person who is responsible for Payment of Patient's Account Emergency Contact Same as Patient Name: Name: DOB: Social Security Number: Phone Number: City, State, Zip: Phone Number: Phone Number: Spouse Child Relation to Patient: (*Proof of Legal Status is Required) Spouse Child Self Parent Guardian Custodial Parent*	Insurance In	nformation							
Image:	I do not have Medical Insurance Insurance Company Name: Medical Policy #: Policyholder Name: Policyholder Date of Birth:			I do not have Dental Insurance Insurance Company Name: Dental Policy #: Policyholder Name: Policyholder Date of Birth:					
Name: DOB: Social Security Number: DOB: Social Security Number: Phone Number: Address: Phone Number: City, State, Zip: Relation to Patient: Phone Number: Image: Classical	Responsible Party Information - Person who is responsible for Payment of Patient's Account			Emergency Contact					
Address:	 Name:	atient	ООВ:						
City, State, Zip: Interaction to Fatient. Phone Number: □ Spouse □ Child □ Other Family Member □ Neighbor □ Friend □ Self Guardian Custodial Parent* □ Neighbor □ Friend □ Self Guardian Custodial Parent* □ Self Guardian Custodial Parent* □ Self				Phone Number:					
Relationship to Patient: (*Proof of Legal Status is Required)				Relation to Patient:					
SelfParentGuardianCustodial Parent*	Phone Number:			□ Spouse		Other Family	ily Member		
	SelfParentGuardianCustodial Parent*		🗆 Neighbor	□ Friend					

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of the North Cou	INI

Date:

Marital Status	Language		Racial Group(s)					
Divorced	□ English			□ American Indian/Alaska Native				
Legally Separated	🗆 Español		Asian Indian					
□ Married	🗆 Français		🛛 🗆 Black/African Americar	1				
□ Partner	□ Other		🗆 Chinese					
□ Single	Do you need an	interpreter?	🗆 Filipino					
□ Widowed	□ Yes □1	No	🛛 Guamanian or Chamor	ro				
Other Characteristic(s)	Ethnicity		🗆 Japanese					
□ Amish	□ Chicano		🗆 Korean					
□ Homeless	🗆 Cuban							
Individual with a Developmental Disab	ility 🗆 Mexican			Other Pacific Islander				
☐ Migrant Worker	/ 🗌 Mexican Americ	an	🗆 Samoan					
□ Seasonal Worker		□ Not Hispanic/Latino						
□ Veteran	□ Puerto Rican		White/Caucasian					
	□ Other		□ Other					
 Choose not to report 	□ Decline to Spec		□ Decline to Specify					
Employment/Education Information		li y	. ,					
		□ Student Full-Time	□ Student Part-T	imo				
 Employed Full-Time Unemployed Part-Time Retired 								
Employer Name:		Other School/College Name		:				
• • • • • • • • • • • • • • • • • • • •	$\frac{1}{2}$	Are vou covered by vo	our School's Insurance? □\	/es ⊓No				
Are you covered by your Employer's Insurance? Yes No Are you covered by your School's Insurance? Yes No								
Pharmacy Information		In 14 - Iver v 4- 4- v 4 v		l				
Preferred Pharmacy:		Is it okay to text you appointment confirmations and notifications of prescriptions sent to your Pharmacy?						
City/State:	· · · · · · · · · · · · · · · · · · ·	□ Yes □ No		- y .				
Other Information								
How did you hear about us?		Primary Care Provider:						
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:			Consent to Discuss PHI					
Name: Re	elationship:	Phone:	Yes	<u>Minor</u> □ Yes				
Name: R	elationship:	Phone:	Yes	🗆 Yes				
Name: R	elationship:	Phone:	Yes	□ 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:						