LAKESHORE community health care

Date: _____/_____/_____

☐ Medical ☐ Dental

How did you hear about us? _____

DEMOGRAPHIC INFORMATION

First Name: _____ MI: _____ Last Name: _____

Previous last name(s) used by patient: _____

Date of Birth: ____/_____/_____ Social Security Number: _____/_____/_____

Patient's address: _____Apt/Lot #_____City: _____ State: ____ Zip code: _____

Primary phone number: _____ ☐ Home ☐ Work ☐ Cell

Secondary phone number: _____ ☐ Home ☐ Work ☐ Cell

Email Address: _____

Preferred Language: ☐ ENGLISH ☐ SPANISH OTHER: _____ Interpreter Needed: ☐ YES ☐ NO

Is patient employed: ☐ YES ☐ NO Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed
☐ Student ☐ Active Military ☐ Retired

ADDITIONAL INFORMATION- ***PLEASE CHECK ALL THAT APPLY***

Marital Status
☐ Divorced
☐ Legally Separated
☐ Married/ Civil Union
☐ Significant Other
☐ Single
☐ Widowed
☐ Other

Race
☐ American Indian/ Alaskan Native
☐ Asian
☐ Black/ African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White

Ethnic Group
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Gender at Birth
☐ Male
☐ Female

Gender Identity
☐ Female
☐ Male
☐ Transgender Male to Female
☐ Transgender Female to Male
☐ Other
☐ Choose Not to Disclose

Farm Worker Status
☐ Migrant Farm Worker
☐ Neither
☐ Seasonal Farm Worker

Veteran status
☐ Yes
☐ No

Homeless Status
☐ Homeless Shelter
☐ Not Homeless
☐ Street
☐ Transitional
☐ Other

Additional Assistance
☐ Wheelchair
☐ Hearing Impaired
☐ Visually Impaired
☐ Speech Impaired

Sexual Orientation
☐ Bisexual
☐ Straight
☐ Lesbian or Gay
☐ Something Else
☐ Don't Know
☐ Choose Not to Disclose

Family Size: _____

Estimated Annual Family Income Level:

☐ Under $12,500
☐ $12,501- $17,500
☐ $17,501- $21,500
☐ $21,501-$25,500
☐ $25,501-$30,500
☐ $30,501-$35,500
☐ $35,501- $39,500
☐ $39,501- $43,500
☐ $43,501- $48,500
☐ $48,501-$52,500
☐ Over $52,500

Who is legally responsible for the patient's medical and dental healthcare decisions?

☐ Self ☐ Parent ☐ Kinship ☐ Guardian ☐ Power of Attorney ☐ Case Worker

Name: _____ Phone Number: _____

Address, City, State, Zip: _____

Preferred Method of Communication: ☐ Telephone ☐ Email _____

Patient lives at: ☐ Personal Home ☐ Facility/ Group Home ☐ Other _____

***** Please provide a copy of the custodial order documentation.*** *For example: Guardianship order, POA Health Care Agent designation, Medical Service Consent, etc.*

Medical Insurance Information ☐ I CURRENTLY DO NOT HAVE MEDICAL INSURANCE

Name of insurance company: _____

Group/ Policy #: _____

Member ID #: _____

If policy holder is someone other than patient, please complete the following information:

Subscriber of insurance: _____

Subscriber Date of Birth: _____/ _____/ _____

Subscriber Social Security Number: _____/ _____/_____

Dental Insurance Information ☐ I CURRENTLY DO NOT HAVE DENTAL INSURANCE

Name of insurance company: _____

Group/ Policy #: _____

Member ID #: _____

If policy holder is someone other than patient, please complete the following information:

Subscriber of insurance: _____

Subscriber Date of Birth: _____/ _____/ _____

Subscriber Social Security Number: _____/ _____/_____

Emergency Contact Information:

Name: _____

Phone: _____

Relationship to Patient: _____