1st Review: ______________
2nd Review: ______________
3rd Review: ______________

Demographic Form

OHHS receives Federal grant money to help sustain our clinics and many of the questions are required by the Grant. Thank you!

PART 1 – GENERAL/PERSONAL INFORMATION **TODAY'S DATE: ____________________________**

LAST NAME: ____ DATE OF BIRTH: ______________________________

FIRST NAME: ____ MIDDLE INITIAL: ______________________________

MAILING ADDRESS: ____

CITY: ____ STATE: _________ ZIP CODE: _______________________

HOME PHONE NUMBER: __________________________________ CELL PHONE NUMBER: ___________________________

SOCIAL SECURITY NUMBER: _________________________________ COUNTY: ______________________________________

E-MAIL ADDRESS: ____

MARITAL STATUS (CHECK ONE): MARRIED DIVORCED SEPARATED SINGLE WIDOWED OTHER

SPOUSE NAME: ____ SPOUSE'S DATE OF BIRTH: _____________________________

EMERGENCY CONTACT: ____________________________ RELATIONSHIP: ______________ PHONE: ______________________

RESPONSIBLE PARTY (IF PATIENT IS YOUNGER THAN 18 YEARS):

LAST NAME: ______________________________________ FIRST NAME: _____________________ MIDDLE INITIAL: ______

MAILING ADDRESS: ____

CITY: ____ STATE: _________________ ZIP CODE: _______________________

PHONE NUMBER: _________________________________ RELATIONSHIP TO PATIENT: _________________________________

DATE OF BIRTH OF RESPONSIBLE PARTY: _____/_____/__________ SOCIAL SECURITY NUMBER: ________________________

GENDER (CHECK ONE):
- MALE
- FEMALE
- OTHER
- TRANSGENDER MALE (FEMALE TO MALE)
- TRANSGENDER FAMALE (MALE TO FEMALE)
- CHOOSE NOT TO DISCLOSE

RACE (CHECK ONE):
- WHITE
- ASIAN
- OTHER – PACIFIC ISLANDER
- AFRICAN AMERICAN/BLACK
- AMERICAN INDIAN/ALASKA NATIVE
- OTHER: ____________________

LANGUAGE (CHECK ONE):
- ENGLISH
- SPANISH
- OTHER: ____________________
- INDIAN (INCLUDING HINDI)
- RUSSIAN

WILL THE PATIENT REQUIRE A TRANSLATOR? YES or NO

ETHNICITY (CHECK ONE): NON-HISPANIC/LATINO HISPANIC/LATINO

SEXUAL ORIENTATION (CHECK ONE – IF YOU ARE 18 YEARS OR OLDER):
STRAIGHT OR HETEROSEXUAL (not lesbian or gay)
HOMOSEXUAL (lesbian or gay)
BISEXUAL
SOMETHING ELSE
DON'T KNOW
CHOOSE NOT TO DISCLOSE

ARE YOU A VETERAN? YES or NO

NAME OF PHARMACY: ____ LOCATION: ________________________

PART 2 - EMPLOYMENT

EMPLOYER: ____

EMPLOYMENT STATUS (CHECK ONE): FULL-TIME PART-TIME SELF-EMPLOYED UNEMPLOYED
RETIRED ACTIVE MILITARY

EMPLOYER'S ADDRESS AND PHONE NUMBER: ____

DO YOU ATTEND SCHOOL? YES or NO IF YES, FULL-TIME: __________ OR PART-TIME: __________

PART 3 – HEALTH and/or DENTAL INSURANCE INFORMATION/RESPONSIBLE PARTY INFORMATION

HEALTH and/or DENTAL INSURANCE (PLEASE GIVE ALL CURRENT CARDS TO RECEPTIONIST TO COPY) If you have more than one insurance, please let the receptionist know which is primary. If you are having dental services, we will still need your health insurance information.

HEALTH and/or DENTAL INSURANCE NAME: ____

POLICY/MEMBER ID NUMBER: ____ GROUP NUMBER: ____________________________

CARD HOLDER/MEMBER: FIRST AND LAST NAME: ____

MAILING ADDRESS: ____

CITY: ____ STATE: _________ ZIP CODE: ___________________________________

SOCIAL SECURITY NUMBER: ____ DATE OF BIRTH: _____/______/_________

PHONE NUMBER: _______________________________________ RELATIONSHIP TO PATIENT: ______________________________

I authorize consent for treatment and to provide medical care to patient listed on form for Ohio Hills Health Services. The patient, parent or guardian retains the right to refuse any treatment/tests they deem unnecessary after consultation with doctor/physician assistant/nurse practitioner. This consent will remain in effect until revoked in writing. If revoked, OHHS reserves the right not to provide services.
I authorize Ohio Hills Health Services to use and/or disclose my health information to carry out treatment, payment, and healthcare operations. Healthcare operations include but not limited to release of my medical information to any physicians and their offices and insurance companies participating in my care or treatment.

I hereby assign all information I have provided is correct to the best of my knowledge. I hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare, Medicaid, commercial and any other health plan to Ohio Hills Health Services. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by insurance that was given. I authorize and request insurance payments be paid directly to Ohio Hills Health Services.

Signature: ____ Date: ______________________

Patient or Parent/Guardian if patient is under the age of 18 years