

Tri-Lakes Community Health Center: Adult Patient Information and Consent Form

Name: Last: _____ First: _____ MI: _____

Mailing Address _____ City _____ State _____ Zip _____

County _____ Phone # _____ Cell # _____ Alt # _____

Date of Birth ____ / ____ / ____ Age ____ Sex M / F

Gender Identity: Male Female Transgender Other

Sexual Orientation: Straight Gay/Lesbian Bisexual Other

Marital Status: S M D W

Soc Sec# ____ - ____ - ____ E-Mail Address _____

Spouse Name: _____ Contact # _____

I **do not** want to be contacted by email for: General health information including the quarterly newsletter
 Specific medical info about my health condition(s) Direct contact with my provider Fundraising

Please indicate if you are: Homeless Migrant Farm worker

Are you a Veteran Yes No

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

Are you of Hispanic/Latino origin? Yes No

Are you disabled? Yes No Current Student? No Full Time Part Time

Education Level: Less than High School HS Diploma Some College/Vocational College Grad

Highest grade of school completed (circle one) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Is your primary language English? Yes No If no, please specify _____

Emergency Contact Person: _____ Phone: _____

Family Size _____ Annual Family Income (please circle) Less than \$10,000
\$10,001 to \$25,000
\$25,001 to \$40,000
\$40,001 to \$55,000
\$55,001 to \$70,000
Greater than \$70,000

How did you hear about our clinic?

friend/family newspaper (please list) _____ website
 yellow pages sign in front of clinic billboard (Branson West) billboard (Reeds Spring)
 other _____ billboard (south of Kimberling City) school

Why are we asking for so much information? Tri-Lakes Community Health Center is a not-for-profit community health center, and as a non-profit, we can apply for grants to expand services. Many grant organizations request we provide demographic information about the patients we serve. Your privacy is important to us, we do not share your personal information or identity with third parties or advertising agents.

RESPONSIBLE PARTY/EMPLOYER INFORMATION/INSURANCE CARRIER
(Please give all insurance cards to the receptionist)

Person responsible for bill: _____ Date of birth: ____ / ____ / ____

Address (if different): _____ Phone: _____

Employer: _____ Employer Phone: _____

