BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

Name: ______________________________ MI: _______ Last Name: __________________________________

Address: ___________________________________City________________ State ________ Zip Code ___________

Date of Birth: _____________________ Social Security #:______________________

Home Phone: __________________ Cell Phone: ______________________________

Employer Name: _____________________________ Work Phone: ____

Emergency Contact Name: __________________________Relationship:_____________ Phone #:________________

Primary Care Provider, *If not BMRHC PCP, obtain ROI:* ________________________ PCP Ph Number_____________

Parent/Guardian Name:___________________________ Address: _____________________________________

Social Security #______________ DOB:___________

Please complete the following section IN REGARDS TO THE PATIENT:

Please select the patient's **Race:**

- White/Caucasian
- Chinese
- Asian Indian
- Guamanian
- Other Pacific Islander
- African American/ Black
- Filipino
- Vietnamese
- More than one Race
- Hispanic/White
- Japanese
- Other Asian
- Native Hawaiian
- Asian
- Korean
- Samoan
- American Indian
- Refuse to Report

Please select the patients **Ethnicity:**

- Non-Hispanic/Latino
- Hispanic/Latino/a (if yes, please select the sub-category below:)
  - Mexican/ Mexican American
  - Hispanic/Latino/a and Spanish Combined
  - Puerto Rican
  - Cuban
  - Another Hispanic/ Latino or Spanish

- **Primary Language (Circle):** English, Indian, Spanish, Russian, Marshallese, Other
- **Marital Status (Circle):** Single, Married, Divorced, Widowed, Legally Separated, Partner, Unknown
- **Veteran (Circle):** Yes/No
- **Education Level (Circle):** Some High School, GED, High School Graduate, Some College, College Graduate
- **Communication Needs (Circle):** None, Visually Impaired, Hearing Impaired, Cognitive Impairment
- **Transportation Barrier (Circle):** Yes,No
- **Sex at Birth:** Male, Female
- **Gender Identity (Circle):** Male, Female, Female to Male/Transgender Male/Trans Man, Male Female/Transgender Female/Trans Woman, Genderqueer, neither exclusively male nor female, Choose not to disclose, Additional Gender Catego
- **Transgender: (Circle)** if Yes
- **Sexual Orientation (Circle)**: Lesbian/Gay/Homosexual, Straight/Heterosexual, Bisexual, Do Not Know, Something Else, Choose not to disclose

Agricultural Worker: Yes/No *(If "Yes," please specify: seasonal, migrant, employed farm worker, unemployed farm worker)*

Homeless: Yes/No *(If "Yes," please specify: homeless shelter, street, transitional, doubling up, other)*

PROVIDE INSURANCE CARDS TO FRONT OFFICE PERSONNEL

PREFERRED PHARMACY ___________________________________

Patient Responsible Party Signature ____ **Date**________________

I hereby certify that the above information is correct

Nombre: ______________________________ Inicial inicial: _______ Apellido: __________________________________

Dirección: ___________________________Ciudad________________ Estado ________ Código Postal ___________

Fecha de nacimiento: _____________________Seguridad Social #:___________________

Teléfono de casa: __________________ Teléfono celular: ____________________________

Nombre del empleador: ___________________________Teléfono del trabajo:______________________________