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:____________

<u>Please complete the following section IN REGARDS TO THE PATIENT</u>:

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

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Asian Indian
- ☐ Guamanian
- ☐ Other Pacific Islander
- ☐ African American/ Black
- ☐ Filipino
- ☐ Vietnamese
- ☐ Hispanic/White
- ☐ Japanese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Korean
- ☐ Samoan
- ☐ American Indian
- ☐ Declined to Specify/Refuse to Report

Please select the patient's **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
- **Sex at Birth:** Male, Female, Unknown
- **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, Other, Unknown
- **Sexual Orientation (Circle)**: Lesbian/Gay/Homosexual, Straight/Heterosexual, Bisexual, Do Not Know, Something Else, Choose not to disclose

Agricultural Worker: Yes/No, *Seasonal Yes/No, Migrant Yes/No*

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

<u>PROVIDE INSURANCE CARDS TO FRONT OFFICE PERSONNEL</u>

If you have an Air Transport Membership, please list your coverage: ___________________________________

PREFERRED PHARMACY ______________________________________

Hereby certify that the above information is correct

Patient Responsible Party Signature ____Date__________________

Form Last Updated: 12/6/23, 6/26/24, 10/24