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/Chamorro
- ☐ Other Pacific Islander
- ☐ African American/ Black
- ☐ Filipino
- ☐ Vietnamese
- ☐ Hispanic/White
- ☐ Japanese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Korean
- ☐ Samoan
- ☐ American Indian/Alaska Native
- ☐ 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

Agricultural Worker: Yes/No, S*easonal Yes/No, Migrant Yes/No*

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

PROVIDE INSURANCE CARDS TO FRONT OFFICE PERSONNEL

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**_____