BULLHOOK Community Health Center

Patient Demographics Form

Please Print

Legal Name (Last, First, MI)	Date of Birth:	Preferred First Name

Mailing Address:	City:	State	Zip

Physical Address:	City:	State:	Zip

Cell Phone:	Home Phone:	Work Phone:	Social Security Number:
		☐Yes, contact me at work	

Email:	GENDER:
☐ Do not have Email ☐ Will not Disclose ☐ Other:	☐ Female ☐ Male

Opting out of Messages:

We are an automated practice with regular text messaging and email to provide helpful information to our patients like appointment reminders, clinic forms to fill out prior to appointments, patient statements and payments. Text messages and emails that contain health information are secured by a technical process called encryption and require identity verification. If you do not want to be contacted by Bullhook Community Health Center by text or email, please indicate below.

☐ EMAIL: NO, please do not communicate with me by regular email. (Please note that by marking NO, you will not be able to access patient portal services or telehealth services)

☐ TEXT: NO, please do not communicate with me by regular text messaging.

Emergency Contact Information		
Contact Name (Last, First)	Contact Phone number:	Relationship to you?
Contact Name (Last, First)	Contact Phone number:	Relationship to you?
Contact Name (Last, First)	Contact Phone number:	Relationship to you?

Please list all individuals you would like to allow access to your Protected Health Information, and which records they can access. (HIPAA) You have the right to deny or approve anyone's access to your information.

*Drug and/or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Part 160 and 164. Information cannot be disclosed without written authorization unless otherwise provided for by the regulations.

Name (Last, First)

Relationship to you:	Contact Phone:

Grant access to: ☐ **Medical** Records ☐ **Dental** Records ☐ **Mental Health** Records ☐ **Financial** Records

*LAC Provider Records must sign or no access Patient Signature: _____ Date: _____

Name (Last, First)

Relationship to you:	Contact Phone:

Grant access to: ☐ **Medical** Records ☐ **Dental** Records ☐ **Mental Health** Records ☐ **Financial** Records

*LAC Provider Records must sign or no access Patient Signature: _____ Date: _____

Name (Last, First)

Relationship to you:	Contact Phone:

Grant access to: ☐ **Medical** Records ☐ **Dental** Records ☐ **Mental Health** Records ☐ **Financial** Records

*LAC Provider Records must sign or no access Patient Signature: _____ Date: _____

Federally Qualified Health Centers have requirements to get grant dollars, and one is to report on the population poverty levels at Bullhook Community Health Center. Please fill out the information below for reporting purposes only *You must answer*:

Number of people Living in your household? _____

Household income: (please check the box that best describes your household gross income)

☐ 0- $14,580 ☐ $14,581- $18,225 ☐ $18,226- $21,870 ☐ $21,871- $25,515 ☐ $25,516- $29,160

☐ $29,161- $50,000 ☐ $50,001- $65,000 ☐ $65,001- $75,000 ☐ $75,001- $80,000 ☐ $80,001- $90,000

☐ greater than $90,001

Federally Qualified Health Centers offer a sliding fee discount. Would you like to see if you are eligible for a discount on your care?

☐ Yes ☐ No

If yes, you must fill out the required forms and provide proof of income per the requirement of our grant funding. You will also be asked to make your nominal fee payment per the department you are being seen in.

We encourage all patients to apply for the discount program even if you have insurance.

Please ask Bullhook staff for an application.

Have you served in the military or armed forces? This includes: Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves?

☐Yes ☐ NO

Note to Dental Patients: please fill out your medical and dental insurance information. If you are here only for dental services, we still need your medical insurance information in the event any procedure done is also covered on your medical insurance so please fill both sections out.

What type of insurance do you have? Check all that apply:

☐ Medicare or Medicare Advantage

☐ Medicaid

☐ Auto accident (Claim # _____)

☐ Worker's compensation (Claim # _____)

☐ Medicare Supplemental Insurance

☐ Private Insurance

☐ VA or military insurance

☐ No insurance

PRIMARY MEDICAL INSURANCE (If you are seeing Dental you still need to fill this out)

Insurance Name: _____ Group Number: _____

Subscriber number: _____ Active Date: _____

Insurance billing address (*usually on back of card)*: _____

If the insured party is someone other than yourself, we need their information in order to submit your claim ⇒

Policy holder Name: _____ Date of birth: _____

Gender: ☐ Male ☐ Female Primary Phone Number: _____☐Cell ☐LAN Line

Employer: _____ SSN:_____ _____

SECONDARY MEDICAL INSURANCE (If you are seeing Dental you still need to fill this out)

Insurance Name: _____ Group Number: _____

Subscriber number: _____ Active Date: _____

Insurance billing address (*usually on back of card)*: _____

If the insured party is someone other than yourself, we need their information in order to submit your claim ⇒

Policy holder Name: _____ Date of birth: _____

Gender: ☐ Male ☐ Female Primary Phone Number: _____☐Cell ☐LAN Line

Employer: _____ SSN:_____ _____

DENTAL INSURANCE PRIMARY

Insurance Name: _____ Group Number: _____

Subscriber number: _____ Active Date: _____

Insurance billing address (*usually on back of card)*: _____

If the insured party is someone other than yourself, we need their information in order to submit your claim ⇒

Policy holder Name: _____ Date of birth: _____

Gender: ☐ Male ☐ Female Primary Phone Number: _____☐Cell ☐LAN Line

Employer: _____ SSN:_____ _____

DENTAL INSURANCE SECONDARY

Insurance Name: _____ Group Number: _____

Subscriber number: _____ Active Date: _____

Insurance billing address (*usually on back of card)*: _____

If the insured party is someone other than yourself, we need their information in order to submit your claim ⇒

Policy holder Name: _____ Date of birth: _____

Gender: ☐ Male ☐ Female Primary Phone Number: _____☐Cell ☐LAN Line

Employer: _____ SSN: _____ _____

Who is your primary care physician? (Whom do you see for your primary medical care)		
Physician's Name:	Facility:	Phone number:

What is your Marital Status?						
☐ Divorced	☐ Married	☐ Partner	☐ Single	☐ Unknown	☐ Widowed	☐Legally Separated

Do you require service provided in a language other than English? ☐ YES ☐ NO

☐ English is my preferred language ☐ I need translation in _____

What is your race or origin? (Check all that apply)

☐ White ☐ American Indian/Alaska Native ☐ Black or African American ☐ Asian Indian☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan
☐ Choose not to disclose

What is your ethnicity? (Select only one)

☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish Origin
☐ Not Hispanic, Latino/a or Spanish Origin ☐ Choose Not to Disclose or report

If not Living in a home you rent, lease, or own please check the best description of your living arrangements:
☐ Doubling Up ☐ Homeless ☐ Migrant ☐ Other ☐ Seasonal ☐ Street ☐ Transitional ☐ Unknown

Employment Status?					
☐ Full-Time	☐ Part-Time	☐ Not employed	☐ Self-employed	☐ Retired	☐ active military duty

Place of Employment:			
Employer Address:	Employer City:	Employer State:	Employer Zip
Employer Phone number:			

Are You a Student?		
☐ Full-Time	☐ Part-Time	☐ Not a student

My Preferred Pharmacy is:

☐ Bullhook Community Health Center Pharmacy
OR
☐ Other: _____

NOTICE OF PRIVACY PRACTICES:

I have received a copy of BCHC's Notice of Privacy Practices informing me of how my medical information may be used and disclosed. This document also explains how I can access medical information for myself and my dependents.

***Signature**: _____ Date: _____*

CONFIRMATION OF INFORMATION PROVIDED:

The information given on this form is true and correct. I understand that it is in my best interest to report all changes in a timely manner.

***Signature**: _____ Date: _____*

Notice of Administrative Use of Confidential Health Care Information:

I have been informed and understand that:

1. Confidential health care information concerning me or the person for whom I am legally responsible for, are recorded in the course of receiving immunizations from this Health Facility in an electronical record and retained in the Montana Immunization Information System – imMTrax.
2. A Prescription History will be obtained concerning me or the person for whom I am legally responsible for, are recorded in the course of receiving care from this Health Facility in an electronical record and retained in Bullhook Community Health Center records unless I specifically direct otherwise.
3. Unless I specifically direct otherwise, the immunization information in imMTrax will be shared with all my immunization providers to help prevent both over- and under-immunization and to create a consolidated vaccine record for me or the person for whom I am legally responsible:
4. Any confidential health care information concerning me or the person for whom I am legally responsible may be used for the administration and direct provision of services that are to be provided to me or to the person for whom I am legally responsible.
5. Health Department and State health care and administrative personnel associated with the delivery of those services and the administration of the programs of services and the imMTrax data system may access the information as necessary for the provision and administration of services. Administration of services may include, but not limited to, the billing of insurers, scheduling of appointments, coordination immunizations, and facilitating enrollment in other programs; and
6. All persons who have access to this confidential information are obligated under federal and state law to protect the information from inappropriate disclosure.

TREATMENT/PAYMENT AGREEMENT FOR Bullhook Community Health Center, INC. (BCHC)

I request the Bullhook Community Health Center, Inc. provide me with medical, dental and/or behavior health care. I accept responsibility to pay for this care according to the fee schedule established. Furthermore, I authorize assignment of benefits for medical, dental and/or behavioral health services to be paid to BCHC. Also, I authorize BCHC to bill my insurance and release information to the insurance company if requested. I will communicate to BCHC any changes to my income and/or insurance status.

I understand and give consent for my information to be accessed by outside entities for the purposes of auditing the facilities' compliance with federal, state, and pharmaceutical program business rules.

_____ Date _____

Patient

_____ Date _____

OR Legal Guardian Signature

*Please provide a copy of your legal guardianship paperwork

_____ _____

If signed by legal guardian, please print name Relationship to patient.