

Patient Demographics Form

Patient's Legal Name (Last, MI, First)			Patient Preferred First Name		
Mailing Address		City	State	Zip + 4	
Physical Address		City	State	Zip + 4	
Home Phone <input type="checkbox"/> LAN Line <input type="checkbox"/> Cell Phone		Cell Phone		Work Phone	
EMAIL ADDRESS:			Preferred Method of Communication: <input type="checkbox"/> Voice <input type="checkbox"/> Text <input type="checkbox"/> Email		

Unencrypted Text Message – Email Language
<p>We offer regular text messaging and email to provide helpful information like appointment reminders. Regular text messages and emails are not secured by technical process called encryption so there may be some level of risk the information could be read by someone besides you. Please let us know if you would like us to communicate with you by text message or email.</p>
<p>EMAIL</p> <p><input type="checkbox"/> Yes, please communicate with me by email. My email address is: _____</p> <ul style="list-style-type: none"> • I will let you know right away if my email address changes. <p><input type="checkbox"/> No, please do not communicate with me by regular (unencrypted email).</p>
<p>TEXT</p> <p><input type="checkbox"/> Yes, please communicate with me by texting. My cell phone number is: _____</p> <ul style="list-style-type: none"> • I will let you know right away if my cell phone number changes. <p><input type="checkbox"/> No, please do not communicate with me by regular (unencrypted text).</p>

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

DATE OF BIRTH:	GENDER AT BIRTH:
SEXUAL ORIENTATION	
<input type="checkbox"/> Lesbian, gay or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Do not know <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Something else, please describe _____ _____	
GENDER IDENTITY	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM) / Transgender Male/Trans Man <input type="checkbox"/> Male-to-Female (MTF) / Transgender Female/Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Additional gender category or other, please specify _____ _____	

MARITAL STATUS						
<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Partner	<input type="checkbox"/> Single	<input type="checkbox"/> Unknown	<input type="checkbox"/> Widowed	<input type="checkbox"/> Legally Separated

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SOCIAL SECURITY NUMBER	/ /
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EMPLOYMENT STATUS					
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Not employed	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Retired	<input type="checkbox"/> active military duty
EMPLOYER NAME					
Employer Address:		Employer City:	Employer State:	Employer Zip	
Employer Phone number:			Employer fax:		

ARE YOU A STUDENT?
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a student

Emergency Contact Information			
Contact full Name:		Contact Address:	
Contact Phone number:		City	State Zip
Relationship to you?			

Federally Qualified Health Centers have requirement's in order to get grant dollars and one is to report on the population poverty levels we see at Bullhook Community Health Center. Please fill out the information below for reporting purposes only:

Number of people Living in your household? _____

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

Less than \$12,140
 \$12,141 - \$18,210
 \$18,211 - \$24,280
 \$24,281 - \$30,000
 \$31,000 - \$35,000
 \$36,000 - \$40,000
 \$41,000 - \$45,000
 \$46,000 - \$55,000
 \$56,000 - \$60,000
 \$61,000 - \$65,000
 \$66,000 - \$70,000
 \$71,000 - \$75,000
 greater than \$75,000

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 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 required per the department you are being seen in as follows.

Medical Department \$10.00 Dental Department \$50.00 Behavioral Health Department \$10.00

We encourage all patient to apply for the discount program even if you have insurance. **Please ask Bullhook staff for an application.**

INSURANCE INFORMATION

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

- | | |
|---|--|
| <input type="checkbox"/> Medicare or Medicare Advantage | <input type="checkbox"/> Medicare Supplemental Insurance |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> Auto accident (Claim # _____) | <input type="checkbox"/> VA or military insurance |
| <input type="checkbox"/> Worker's compensation (Claim # _____) | <input type="checkbox"/> 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): _____
 Who carries this insurance (insured party)? _____

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

Name: _____ Date of birth: _____
 Gender: _____ Phone: _____
 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): _____
 Who carries this insurance (insured party)? _____

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

Name: _____ Date of birth: _____
 Gender: _____ Phone: _____
 Employer: _____ SSN: _____

DENTAL INSURANCE PRIMARY

Insurance Name: _____ Group Number: _____
 Subscriber number: _____ Active Date: _____
 Insurance billing address (usually on back of card): _____
 Who carries this insurance (insured party)? _____

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

Name: _____ Date of birth: _____
 Gender: _____ Phone: _____
 Employer: _____ SSN: _____

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DENTAL INSURANCE SECONDARY

Insurance Name: _____ Group Number: _____

Subscriber number: _____ Active Date: _____

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

Who carries this insurance (insured party)? _____

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

Name: _____ Date of birth: _____

Gender: _____ Phone: _____

Employer: _____ SSN: _____

ADDITIONAL INFORMATION (federally mandated questions)

What is your race or origin? Check all that apply:

- American Indian or Alaska Native
 White
 Black or African American
 Asian
 Other
 Native Hawaiian or other Pacific Islander
 Choose not to disclose

What is your ethnicity?

- Hispanic or Latino
 Not Hispanic or Latino
 Declined to Specify

What is your Primary Language? Will you require a translator? YES NO

- English
 Other _____

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

- Yes
 No

Please check the statement which best describes your housing situation:

- I live in my home which I rent, lease, or own
 I am staying with a series of friends and/or extended family members on a temporary basis
 I am staying in supportive or transitional housing (such as a sober living facility or recovery home)
 I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility or motel)
 I have been released from an institution (such as a jail or hospital) without stable housing to return to
 I live on the streets, in a car, park sidewalk, in an abandoned building, or any unstable or non-permanent situation
 I live in a foster care environment

My Preferred Pharmacy is: Bullhook Community Health Center Pharmacy
 Other: _____

Patient Demographics Form

Please list all individuals you would like to allow access to your Protected Health Information and which records they can access. 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, MI, First)

Relationship to you

Contact Phone

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

*Substance Abuse Records Patient Signature: _____ Date: _____

Name (Last, MI, First)

Relationship to you

Contact Phone

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

*Substance Abuse Records Patient Signature: _____ Date: _____

Name (First, MI, Last)

Relationship to you

Contact Phone

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

*Substance Abuse Records Patient Signature: _____ Date: _____

Do you have a dentist you see regularly? Yes No **If yes, who?**

Have you seen a dentist in the past year? Yes No **If yes, who?**

Have you recently had a toothache or other problems with your teeth? Yes No

We currently are offering services through Montana Legal Service Association (MLSA)

Do you understand the assistance offered through the Montana Legal Association? Yes No

Would you like to request assistance from the MLSA program? Yes No

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: _____

Patient Demographics Form

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 electronic record and retained in the Montana Immunization Information System – imMTrax.
2. 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:
3. 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.
4. 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
5. 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.

Patient or parent/*legal guardian signature

Date

If signed by parent/legal guardian, please print name

Relationship to patient

***Please provide a copy of your legal guardianship paperwork**

<p>BCHC STAFF USE ONLY</p> <p>Form received & Processed by: _____</p> <p>Review Date: _____</p>	<p>Slide set? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>
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