

## Adolescent Demographic 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	

<b>If patient is under 18 years of age, please fill out the following:</b>		
Father's Legal Name (First, MI, Last)		
Social Security #	DOB (MM/DD/YYYY)	Contact Phone
Physical Address (City, State, Zip) <i>if different than child</i>		

Mother's Legal Name (First, MI, Last)		
Social Security #	DOB (MM/DD/YYYY)	Contact Phone
Physical Address (City, State, Zip) <i>if different than child</i>		

<b>If legal guardian is someone other than the birth parent, please fill out the information below and provide guardianship documentation.</b>		
Guardian's Legal Name (First, MI, Last)		
Social Security #	DOB (MM/DD/YYYY)	Contact Phone
Physical Address (City, State, Zip) <i>if different than child</i>		

<b>Unencrypted Text Message – Email Language</b>
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.
<b>EMAIL</b> <input type="checkbox"/> <b>Yes</b> , please communicate with me by email. My email address is: _____ • I will let you know right away if my email address changes. <input type="checkbox"/> <b>No</b> , please do not communicate with me by regular (unencrypted email).
<b>TEXT</b> <input type="checkbox"/> <b>Yes</b> , please communicate with me by texting. My cell phone number is: _____ • I will let you know right away if my cell phone number changes. <input type="checkbox"/> <b>No</b> , please do not communicate with me by regular (unencrypted text).

## Adolescent Demographic Form

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

DATE OF BIRTH:	GENDER AT BIRTH:
<b>SEXUAL ORIENTATION</b>	
<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 _____ _____	
<b>GENDER IDENTITY</b>	
<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 _____ _____	

<b>MARITAL STATUS</b>						
<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

<b>SOCIAL SECURITY NUMBER</b>	/ /
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<b>EMPLOYMENT STATUS</b>						
<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:		

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

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

**Federally Qualified Health Centers** have requirements 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:

## Adolescent Demographic Form

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

**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 provider 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)? \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

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

## Adolescent Demographic Form

### 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: \_\_\_\_\_

### 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

## Adolescent Demographic Form

<b>Please check the statement which best describes your housing situation:</b>	
<input type="checkbox"/> I live in my home which I rent, lease, or own <input type="checkbox"/> I am staying with a series of friends and/or extended family members on a temporary basis <input type="checkbox"/> I am staying in supportive or transitional housing (such as a sober living facility or recovery home) <input type="checkbox"/> I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility or motel) <input type="checkbox"/> I have been released from an institution (such as a jail or hospital) without stable housing to return to <input type="checkbox"/> I live on the streets, in a car, park sidewalk, in an abandoned building, or any unstable or non-permanent situation <input type="checkbox"/> I live in a foster care environment	
<b>My Preferred Pharmacy is:</b> <input type="checkbox"/> Bullhook Community Health Center Pharmacy <input type="checkbox"/> Other: _____	
<b>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.</b> <b>*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.</b>	
Name (Last, MI, First)	
Relationship to you	Contact Phone
Grant access to: <input type="checkbox"/> Medical Records <input type="checkbox"/> Dental Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Financial Records *Substance Abuse Records Patient Signature: _____ Date: _____	
Name (Last, MI, First)	
Relationship to you	Contact Phone
Grant access to: <input type="checkbox"/> Medical Records <input type="checkbox"/> Dental Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Financial Records *Substance Abuse Records Patient Signature: _____ Date: _____	
Name (First, MI, Last)	
Relationship to you	Contact Phone
Grant access to: <input type="checkbox"/> Medical Records <input type="checkbox"/> Dental Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Financial Records *Substance Abuse Records Patient Signature: _____ Date: _____	
<b>Do you have a dentist you see regularly?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, Who?</b>	
<b>Have you seen a dentist in the past year?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, Who?</b>	
<b>Have you recently had a toothache or other problems with your teeth?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>We currently are offering services through Montana Legal Service Association (MLSA)</b>	
Do you understand the assistance offered through the Montana Legal Association? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to request assistance from the MLSA program? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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**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 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**



## Adolescent Demographic Form

**BCHC STAFF USE ONLY**

Form received &  
Processed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

Slide set?  Yes  No

Notes: