BULLHOOK
Community Health Center

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 ☐ LAN Line ☐ Cell Phone	Cell Phone	Work Phone	
EMAIL ADDRESS:		Preferred Method of Communication: ☐ Voice ☐ Text ☐ Email	

Unencrypted Text Message – Email Language

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.

EMAIL

☐ **Yes,** please communicate with me by email. My email address is: _____

- I will let you know right away if my email address changes.

☐ **No (Please Note that by marking NO you will not be able to access patient portal services or Telehealth Medicine services)** please do not communicate with me by regular (unencrypted email).

TEXT

☐ **Yes,** please communicate with me by texting. My cell phone number is: _____

- I will let you know right away if my cell phone number changes.

☐ **No,** please do not communicate with me by regular (unencrypted text).

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: ☐ Female ☐ Male

What is your SEXUAL ORIENTATION

☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Do not know ☐ Choose not to disclose

☐ Something else, please describe _____

_____

What is your GENDER IDENTITY

☐ Male ☐ Female ☐ Female-to-Male (FTM) / Transgender Male/Trans Man ☐ Male-to-Female (MTF) / Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Choose not to disclose

☐ Additional gender category or other, please specify _____

_____

What is your MARITAL STATUS

☐ Divorced	☐ Married	☐ Partner	☐ Single	☐ Unknown	☐ Widowed	☐ Legally Separated

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SOCIAL SECURITY NUMBER	/ /

EMPLOYMENT STATUS					
☐ Full-Time	☐ Part-Time	☐ Not employed	☐ Self-employed	☐ Retired	☐ Active Military Duty

EMPLOYER NAME			
Employer Address:	Employer City:	Employer State:	Employer Zip
Employer Phone number:	Employer fax:		

ARE YOU A STUDENT?		
☐ Full-Time	☐ Part-Time	☐ Not a student

Responsible Person for Account Balance and Correspondence Information			
Contact full Name:	Contact Address:		
Contact Phone number:	City	State	Zip
Relationship to you?			

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 ☐ $30,001 - $35,000

☐ $35,001 - $40,000 ☐ $40,001 - $45,000 ☐ $45,001 - $55,000 ☐ $55,001 - $60,000 ☐ $60,001 - $65,000

☐ $65,001 - $70,000 ☐ $70,001 - $75,000 ☐ greater than $75,001

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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:

☐ 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)*: _____

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

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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

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

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

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

☐Yes ☐ No

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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: _____

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

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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:* _____

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. 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.

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_____ _____

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**

BCHC STAFF USE ONLY	Slide set? ☐ Yes ☐ No
Form received & Processed by: _____	Notes:
Review Date: _____	