

**Community Health Center of Yavapai
Patient Demographics**

Patient Label

Last Name:	First Name:	Middle Initial:	Nickname:
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Social Security Number*: _____ **Gender** F M **Date of Birth:** _____
Month/ Day / Year

Mailing Address _____
Address City State Zip

OK TO MAIL LAB RESULTS TO THE ABOVE ADDRESS? Yes No

Physical Address: _____
(If different from mailing address) Street Address City State Zip

Demographics	<ul style="list-style-type: none"> Race: <input type="checkbox"/> White/Hispanic <input type="checkbox"/> White/Non-Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<ul style="list-style-type: none"> Employed Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed
	<ul style="list-style-type: none"> Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other
	<ul style="list-style-type: none"> Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student
	<ul style="list-style-type: none"> Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you receiving medical care through the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No

Phone number best to reach you: _____ **Can we leave messages on this phone?** Yes No

Alternate phone number: _____ **Can we leave messages on this phone?** Yes No

UDS	<ul style="list-style-type: none"> Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<ul style="list-style-type: none"> Are you a migrant or seasonal agricultural worker? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<ul style="list-style-type: none"> Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
	<ul style="list-style-type: none"> Race: <input type="checkbox"/> White <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> More than One Race <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unknown
	<ul style="list-style-type: none"> Ethnicity <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown

Do you have insurance? Yes - Please complete below No- Skip to back of form

Insurance Information	Do you have Medicare Part B? <input type="checkbox"/> Yes ID # _____ <input type="checkbox"/> No
	Do you have AHCCCS? <input type="checkbox"/> Yes Plan Name: _____ ID# _____ <input type="checkbox"/> No
	All Other Insurance - Name of Insurance: _____
	ID#: _____ Group # _____ Effective Date: _____
	Name of the Policy Holder: _____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address of Policy Holder if different from Patient: _____
	Date of Birth of Policy Holder: _____ Social Security Number*: _____
Name of Employer of the Policy Holder: _____ Employer Phone Number: _____	

INSURED PATIENTS: Please present your insurance card to the front desk. Also your income may qualify you to pay less.

I decline to provide income information _____ OR circle your income under your family size below:

FAMILY SIZE	<=100% FPL	101 - 125% FPL	126 - 150% FPL	151-175% FPL	176-200% FPL	201-225% FPL	226 - 250% FPL	251% > FPL
1	\$0 - 10,830	10,831 - 13,538	13,539 - 16,245	16,246 - 18,956	18,954 - 21,660	21,661 - 24,368	24,369 - 27,075	27,076 % >
2	\$0 - 14,570	14,571 - 18,438	18,439 - 21,855	21,856 - 24,498	25,499 - 29,140	29,141 - 32,783	32,784 - 36,426	36,426 >
3	\$0 - 18,310	18,311 - 22,888	22,889 - 27,465	27,466 - 32,043	32,044 - 36,620	36,621 - 41,198	41,199 - 45,775	45,776 >
4	\$0 - 22,050	22,051 - 27,563	27,564 - 33,075	33,076 - 38,588	38,589 - 44,100	44,101 - 49,613	49,614 - 55,125	55,126 >
5	\$0 - 25,790	25,791 - 32,238	32,239 - 38,685	38,686 - 45,133	45,134 - 51,580	51,581 - 58,028	58,029 - 64,475	64,476 >
6	\$0 - 29,530	29,531 - 36,913	36,914 - 44,295	44,296 - 51,678	51,679 - 59,060	59,061 - 66,443	66,444 - 73,825	73,826 >
7	\$0 - 33,270	33,271 - 41,588	41,589 - 49,905	49,906 - 58,223	58,224 - 66,540	66,541 - 74,858	74,859 - 83,175	83,176 >
8	\$0 - 37,010	37,011 - 46,263	46,264 - 55,515	55,516 - 64,768	64,769 - 74,020	74,021 - 83,273	83,274 - 92,525	92,526 >
Added persons	3,740	4,675	5,610	6,545	7,480	8,415	9,350	9,351

Responsible Party Information for patients under 18 UNLESS appointment is for Reproductive Health	
RESPONSIBLE PARTY	MOTHER/GUARDIAN: Last Name: _____ First Name: _____ Date of Birth ____/____/____ Your mailing address: _____ City: _____ State: _____ Zip: _____ (If Different than the Patient)
	FATHER/GUARDIAN: Last Name: _____ First Name: _____ Date of Birth ____/____/____ Your mailing address: _____ City: _____ State: _____ Zip: _____ (If Different than the Patient)
	RH PATIENTS ONLY- If you are under the age of 18 and here <u>with</u> your parents you must give the total household income, If you a here without your parents, you only need to give your income. Yearly total household income: _____ Family size who live off this income: _____
	<u>Check All that Apply RACE:</u> <input type="checkbox"/> White <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown Competent in the English Language <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Do you want to give access to your protected health information with anyone? <input type="checkbox"/> Yes (PHI form given _____) <input type="checkbox"/> No <input checked="" type="checkbox"/> IF OVER THE AGE OF 18 - Do you currently have a Living Will or Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please provide us with a copy for your medical records.

Exemptions to Confidentiality

YCCHS will honor your request not to contact you, unless there is an urgent health problem. **In that event, you will be contacted.** Patients who are identified with a positive result to a sexually transmitted disease test will be reported to the Arizona Department of Health Services. If teens under age 18 are suspected of being abused or in a coercive relationship YCCHS is obligated by Arizona State law to report to the local legal authorities.

Consent

I authorize and consent to treatment and services provided by YCCHS. I hereby assign all insurance benefits to YCCHS for services rendered. If I am uninsured or the services rendered are not covered by my insurance carrier or plan, I understand that I am financially responsible for the charges incurred. I have been offered a copy of YCCHS Information Practice Statement #051605.

Patient's (or Guardian) Signature: _____ Date: _____

YCCHS Staff Signature: _____ Date: _____

<p><u>For internal use only:</u></p> <p>New patient packet provided to patient by YCCHS staff: _____</p>	<p>Patient Label:</p>
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