Welcome to Blackstone Valley Community Health Care!

ADOLESCENT DEMOGRAPHIC INTAKE (12-17 Years Old)

PATIENT FIRST NAME_____ MIDDLE INITIAL_____ LAST NAME_____

DOB_____ Patient's Telephone_____ Patient's EMAIL_____

Preferred Language_____ Preferred Name_____

Preferred pronouns ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them , Their ☐ Ze, Hir ☐ Other_____

Street Address_____ APT#_____

City_____State_____Zip_____

Emergency Contact_____Relationship_____Phone#_____

Pharmacy_____Location_____Phone#_____

PATIENT PORTAL: Are you using our patient portal? ___Y ___N

Notification Preferences: How should we reach you?	
☐ Voice Reminders	☐ Text Message
☐ Email	☐ Patient Portal

WHO IS THE LEGAL GUARDIAN: ___Mother __Father __Both ___DCYF ____Other:_____

If in parental custody, what is the marital status of the parents ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If in DCYF custody, type of custody: ☐ Petition has been filed ☐ Temporary ☐ Permanent

Case Worker Name:_____ Phone No._____

If in other family custody, does this person have permission to make medical decisions? ☐ Yes ☐ No

PARENT/GUARDIAN NAME_____DOB _____PHONE #_____

OTHER PARENT/GUARDIAN NAME_____DOB_____PHONE # _____

WE ARE REQUIRED TO OBTAIN THE FOLLOWING INFORMATION PER FEDERAL GUIDELINES

Income Verification *To be considered for a reduced fee, please circle your family size & annual household income.*

Family Size				
1	2	3	4	5
6	7	8	9	10

***Family Size greater than 10 insert size here _____

Annual Income						
$5,000	$10,000	$15,000	$20,000	$25, 000	$30,000	$35,000
$40,000	$45,000	$50,000	$55,000	$60,000	$65,000	$70,000
$75,000	$80,000	$85,000	$90,000	$95,000	$100,000 or greater	

***Total Annual Income_____ Declined to answer ☐

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Housing/Work/Veteran Status *Please check all that apply*
Housing ☐Doubling-up (*sharing a room*) ☐Shelter ☐ Street ☐ Transitional ☐ Permanent Supportive Housing ☐ Not Homeless **Are you any of these** ☐Not a Farm worker ☐Migrant Farm worker ☐ Seasonal Farm worker ☐Veteran ☐Not Veteran

RACE *Check all that apply*		**ETHNICITY** *Check all that apply*
□ White	□ Asian Indian	□ Mexican
□ Native Hawaiian	□ Chinese	□ Mexican American
□ American Indian or Alaska Native	□ Filipino	□ Chicano
□ Pacific Islander	□ Japanese	□ Puerto Rican
□ Guamanian or Chamorro	□ Korean	□ Cuban
□ Samoan	□ Vietnamese	□ Hispanic, Latino
□ Black/African American (Cape Verde)	□ Other Asian	□ Not Hispanic or Latino
	□ Unreported/Refused to Report	□ Declined to answer

Sex assigned at Birth ☐Male ☐Female ☐Undifferentiated

Gender Identity *Please check the gender identity that you most identify with*	
☐ Female	☐ Female to Male (FTM) (Transgender Male/Man)
☐ Male	☐ Male to Female (MTF) (Transgender Female/Woman)
☐ Gender queer, neither exclusively male or female	☐ Choose not to Disclose
☐ Additional gender category/Other _____	

Sexual Orientation *Please check the sexual orientation that you most identify with:*	
☐ Straight (heterosexual)	☐ Don't know
☐ Bisexual	☐ Other/Something Else
☐ Homosexual (lesbian, gay)	☐ Choose not to disclose

Signature of Parent/Legal Guardian_____ Patient's Signature_____

Employee Witness_____ Today's Date_____

FOR BVCHC INTERNAL USE ONLY: Medical Record #_____Staff initials_____

Thank you for selecting Blackstone Valley Community Health Care for your health care needs.
We value our community and welcome you to our health center.

Revised March, 2024